INTERLOCAL AGREEMENT

Washington State Department of Social & Health Services

DSHS Agreement Number: 0861-30708

This Agreement is by and between the State of Washington Department of Social and Health Services (DSHS) and the Contractor identified below, and is issued pursuant to the Interlocal Cooperation Act, chapter 39.34 RCW.

Program Contract Number:

Contractor Contract Number:

CONTRACTOR NAME	CONTRACTOR doing business as (DBA)	
Washington State Department of Health		
CONTRACTOR ADDRESS	WASHINGTON UNIFORM BUSINESS IDENTIFIER (UBI)	DSHS INDEX NUMBER
101 Israel Road PO Box 47095 Tumwater, WA 98501	- -	1497

CONTRACTOR CONTACT	CONTRACTOR TELEPHONE	CONTRACTOR FAX	CONTRACTOR E-MAIL ADDRESS
Johanna Flynn	(360) 236-5319 Ext:	(360) 123-4567	johanna.flynn@doh.wa.gov

DSHS ADMINISTRATION	DSHS DIVISION	DSHS CONTRACT CODE
Health and Recovery Services Administration	Division of Health Services	4700LC-61

DSHS CONTACT NAME AND TITLE	DSHS CONTACT ADDRESS
Todd Slettvet Tribal MAM Program Manager	626 8th Ave PO Box 45508 Olympia, WA 98504-5508

DSHS CONTACT TELEPHONE	DSHS CONTACT FAX	DSHS CONTACT E-MAIL ADDRESS
(360) 725-1626 Ext:	(360) 586-3005	sletttd@dshs.wa.gov

IS THE CONTRACTOR A SUBRECIPIENT FOR PURPOSES OF THIS CONTRACT?	CFDA NUMBER(S)
Yes	93.778

AGREEMENT START DATE	**AGREEMENT END DATE**	MAXIMUM AGREEMENT AMOUNT
1/1/2008	**12/31/2012**	Fee For Service

EXHIBITS. The following Exhibits are attached and are incorporated into this Agreement by reference:

☒ **Exhibits (specify): Exhibit A: Sample A19-1A State of Washington Invoice Voucher; Exhibit B: Semi-monthly Time Sheet; Exhibit C: Tally Sheet; Exhibit D: Sample MER Certification Form; Exhibit E: Monitoring Tool.**

☐ **No Exhibits.**

The terms and conditions of this Agreement are an integration and representation of the final, entire and exclusive understanding between the parties superseding and merging all previous agreements, writings, and communications, oral or otherwise regarding the subject matter of this Agreement, between the parties. The parties signing below represent they have read and understand this Agreement, and have the authority to execute this Agreement. This Agreement shall be binding on DSHS only upon signature by DSHS.

CONTRACTOR SIGNATURE	PRINTED NAME AND TITLE	DATE SIGNED

DSHS SIGNATURE	PRINTED NAME AND TITLE	DATE SIGNED

DSHS General Terms and Conditions

1. Definitions. The words and phrases listed below, as used in this Contract, shall each have the following definitions:

a. "Central Contract Services" means the DSHS central headquarters contracting office, or successor section or office.

b. "Confidential Information" means information that is exempt from disclosure to the public or other unauthorized persons under RCW 42.56 or other federal or state laws. Confidential Information includes, but is not limited to, Personal Information.

c. "Contract" or "Agreement" means the entire written agreement between DSHS and the Contractor, including any Exhibits, documents, or materials incorporated by reference.

d. "Contracts Administrator" means the manager, or successor, of Central Contract Services or successor section or office.

e. "Contractor" means the individual or entity performing services pursuant to this Contract and includes the Contractor's owners, members, officers, directors, partners, employees, and/or agents, unless otherwise stated in this Contract. For purposes of any permitted Subcontract, "Contractor" includes any Subcontractor and its owners, members, officers, directors, partners, employees, and/or agents.

f. "Debarment" means an action taken by a Federal agency or official to exclude a person or business entity from participating in transactions involving certain federal funds.

g. "DSHS" or the "Department" means the state of Washington Department of Social and Health Services and its employees and authorized agents.

h. "Encrypt" means to encipher or encode electronic data using software that generates a minimum key length of 128 bits.

i. "Hardened Password" means a string of at least eight characters containing at least one alphabetic character, at least one number and at least one special character such as an asterisk, ampersand or exclamation point.

j. "Personal Information" means information identifiable to any person, including, but not limited to, information that relates to a person's name, health, finances, education, business, use or receipt of governmental services or other activities, addresses, telephone numbers, Social Security Numbers, driver license numbers, other identifying numbers, and any financial identifiers.

k. "Physically Secure" means that access is restricted through physical means to authorized individuals only.

l. "Program Agreement" means an agreement between the Contractor and DSHS containing special terms and conditions, including a statement of work to be performed by the Contractor and payment to be made by DSHS.

m. "RCW" means the Revised Code of Washington. All references in this Contract to RCW chapters or sections shall include any successor, amended, or replacement statute. Pertinent RCW chapters can be accessed at http://apps.leg.wa.gov/rcw/.

n. "Regulation" means any federal, state, or local regulation, rule, or ordinance.

o. "Secured Area" means an area to which only authorized representatives of the entity possessing the Confidential Information have access. Secured Areas may include buildings, rooms or locked storage containers (such as a filing cabinet) within a room, as long as access to the Confidential Information is not available to unauthorized personnel.

p. "Subcontract" means any separate agreement or contract between the Contractor and an individual or entity ("Subcontractor") to perform all or a portion of the duties and obligations that the Contractor is obligated to perform pursuant to this Contract.

q. "Tracking" means a record keeping system that identifies when the sender begins delivery of Confidential Information to the authorized and intended recipient, and when the sender receives confirmation of delivery from the authorized and intended recipient of Confidential Information.

r. "Transport" means the movement of Confidential Information from one entity to another, or within an entity, that (1) places the Confidential Information outside of a Secured Area or system (such as a local area network) and (2) is accomplished other than via a Trusted System.

s. "Trusted Systems" include only the following methods of physical delivery: (1) hand-delivery by a person authorized to have access to the Confidential Information with written acknowledgement of receipt, and (2) United States Postal Service ("USPS") delivery services that include Tracking, such as Certified Mail, Express Mail or Registered Mail. Any other method of physical delivery will not be deemed a Trusted System.

t. "Unique User ID" means a string of characters that identifies a specific user and which, in conjunction with a password, passphrase or other mechanism, authenticates a user to an information system.

u. "WAC" means the Washington Administrative Code. All references in this Contract to WAC chapters or sections shall include any successor, amended, or replacement regulation. Pertinent WAC chapters or sections can be accessed at http://apps.leg.wa.gov/wac/.

2. Amendment. This Contract may only be modified by a written amendment signed by both parties. Only personnel authorized to bind each of the parties may sign an amendment.

3. Assignment. The Contractor shall not assign this Contract or any Program Agreement to a third party without the prior written consent of DSHS.

4. Billing Limitations.

a. DSHS shall pay the Contractor only for authorized services provided in accordance with this Contract.

b. DSHS shall not pay any claims for payment for services submitted more than twelve (12) months after the calendar month in which the services were performed.

c. The Contractor shall not bill and DSHS shall not pay for services performed under this Contract, if the Contractor has charged or will charge another agency of the state of Washington or any other party for the same services.

5. Compliance with Applicable Law. At all times during the term of this Contract, the Contractor shall comply with all applicable federal, state, and local laws and regulations, including but not limited to, nondiscrimination laws and regulations.

6. Confidentiality.

a. The Contractor shall not use, publish, transfer, sell or otherwise disclose any Confidential Information gained by reason of this Contract for any purpose that is not directly connected with Contractor's performance of the services contemplated hereunder, except:

(1) as provided by law; or,

(2) in the case of Personal Information, with the prior written consent of the person to whom the Personal Information pertains.

b. The Contractor shall protect and maintain all Confidential Information gained by reason of this Contract against unauthorized use, access, disclosure, modification or loss. This duty requires the Contractor to employ reasonable security measures, which include restricting access to the Confidential Information by:

(1) Encrypting electronic Confidential Information during Transport;

(2) Physically Securing and Tracking media containing Confidential Information during Transport;

(3) Limiting access to staff that have an authorized business requirement to view the Confidential Information

(4) Using access lists, Unique User ID and Hardened Password authentication to protect Confidential Information placed on computer systems;

(5) Physically Securing any computers, documents or other media containing the Confidential Information; and

(6) Encrypting all Confidential Information that is stored on portable devices including but not limited to laptop computers and flash memory devices.

c. Upon request by DSHS or at the end of the Contract term, the Contractor shall return the Confidential Information or certify in writing that the Contractor employed a DSHS approved method to destroy the information. Contractor may obtain information regarding approved destruction methods from the DSHS contact identified on the cover page of this Contract.

In the event of a theft, loss, unauthorized disclosure, or other potential or known compromise of Confidential Information, the Contractor shall notify DSHS within one (1) business day of the discovery of the event. Contractor must also take actions to mitigate the risk of loss and comply with any notification or other requirements imposed by law.

7. Debarment Certification. The Contractor, by signature to this Contract, certifies that the Contractor is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency from participating in transactions (Debarred). The Contractor also agrees to include the above requirement in any and all Subcontracts into which it enters. The Contractor shall immediately notify DSHS if, during the term of this Contract, Contractor becomes Debarred. DSHS may immediately terminate this Contract by providing Contractor written notice if Contractor becomes Debarred during the term hereof.

8. Governing Law and Venue. This Contract shall be construed and interpreted in accordance with the laws of the state of Washington and the venue of any action brought hereunder shall be in Superior

Court for Thurston County. In the event that an action is removed to U.S. District Court, venue shall be in the Western District of Washington.

9. Independent Contractor. The parties intend that an independent contractor relationship will be created by this Contract. The Contractor and his or her employees or agents performing under this Contract are not employees or agents of the Department. The Contractor, his or her employees, or agents performing under this Contract will not hold himself/herself out as, nor claim to be, an officer or employee of the Department by reason hereof, nor will the Contractor, his or her employees, or agent make any claim of right, privilege or benefit that would accrue to such officer or employee.

10. Inspection. The Contractor shall, at no cost, provide DSHS and the Office of the State Auditor with reasonable access to Contractor's place of business, Contractor's records, and DSHS client records, wherever located. These inspection rights are intended to allow DSHS and the Office of the State Auditor to monitor, audit, and evaluate the Contractor's performance and compliance with applicable laws, regulations, and these Contract terms. These inspection rights shall survive for six (6) years following this Contract's termination or expiration.

11. Maintenance of Records. The Contractor shall maintain records relating to this Contract and the performance of the services described herein. The records include, but are not limited to, accounting procedures and practices, which sufficiently and properly reflect all direct and indirect costs of any nature expended in the performance of this Contract. All records and other material relevant to this Contract shall be retained for six (6) years after expiration or termination of this Contract.

Without agreeing that litigation or claims are legally authorized, if any litigation, claim, or audit is started before the expiration of the six (6) year period, the records shall be retained until all litigation, claims, or audit findings involving the records have been resolved.

12. Order of Precedence. In the event of any inconsistency or conflict between the General Terms and Conditions and the Special Terms and Conditions of this Contract or any Program Agreement, the inconsistency or conflict shall be resolved by giving precedence to these General Terms and Conditions. Terms or conditions that are more restrictive, specific, or particular than those contained in the General Terms and Conditions shall not be construed as being inconsistent or in conflict.

13. Severability. If any term or condition of this Contract is held invalid by any court, the remainder of the Contract remains valid and in full force and effect.

14. Survivability. The terms and conditions contained in this Contract or any Program Agreement which, by their sense and context, are intended to survive the expiration or termination of the particular agreement shall survive. Surviving terms include, but are not limited to: Billing Limitations; Confidentiality, Disputes; Indemnification and Hold Harmless, Inspection, Maintenance of Records, Notice of Overpayment, Ownership of Material, Termination for Default, Termination Procedure, and Treatment of Property.

15. Termination Due to Change in Funding. If the funds DSHS relied upon to establish this Contract or Program Agreement are withdrawn, reduced or limited, or if additional or modified conditions are placed on such funding, DSHS may immediately terminate this Contract by providing written notice to the Contractor. The termination shall be effective on the date specified in the termination notice.

16. Waiver. Waiver of any breach or default on any occasion shall not be deemed to be a waiver of any subsequent breach or default. Any waiver shall not be construed to be a modification of the terms and conditions of this Contract. Only the DSHS Chief Administrative Officer or designee has the authority to waive any term or condition of this Contract on behalf of DSHS.

Additional General Terms and Conditions – Interlocal Agreements:

17. Disputes. Disputes shall be determined by a Dispute Board. Each party to this Agreement shall appoint one member to the Dispute Board. The members so appointed shall jointly appoint an additional member to the Dispute Board. The Dispute Board shall review the facts, Agreement terms, and applicable statutes and rules and make a determination of the dispute. As an alternative to this process, either party may request intervention by the Governor, as provided by RCW 43.17.330, in which event the Governor's process shall control. Participation in either dispute process shall precede any judicial or quasi-judicial action and shall be the final administrative remedy available to the parties.

18. Hold Harmless.

a. The Contractor shall be responsible for and shall hold DSHS harmless from all claims, loss, liability, damages, or fines arising out of or relating to the Contractor's, or any Subcontractor's, performance or failure to perform this Agreement, or the acts or omissions of the Contractor or any Subcontractor. DSHS shall be responsible for and shall hold the Contractor harmless from all claims, loss, liability, damages, or fines arising out of or relating to DSHS' performance or failure to perform this Agreement.

b. The Contractor waives its immunity under Title 51 RCW to the extent it is required to indemnify, defend, and hold harmless the State and its agencies, officials, agents, or employees.

19. Ownership of Material. Material created by the Contractor and paid for by DSHS as a part of this Contract shall be owned by DSHS and shall be "work made for hire" as defined by Title 17 USCA, Section 101. This material includes, but is not limited to: books; computer programs; documents; films; pamphlets; reports; sound reproductions; studies; surveys; tapes; and/or training materials. Material which the Contractor uses to perform the Contract but is not created for or paid for by DSHS is owned by the Contractor and is not "work made for hire"; however, DSHS shall have a perpetual license to use this material for DSHS internal purposes at no charge to DSHS, provided that such license shall be limited to the extent which the Contractor has a right to grant such a license.

20. Subrecipients.

a. General. If the Contractor is a subrecipient of federal awards as defined by Office of Management and Budget (OMB) Circular A-133 and this Agreement, the Contractor shall:

(1) Maintain records that identify, in its accounts, all federal awards received and expended and the federal programs under which they were received, by Catalog of Federal Domestic Assistance (CFDA) title and number, award number and year, name of the federal agency, and name of the pass-through entity;

(2) Maintain internal controls that provide reasonable assurance that the Contractor is managing federal awards in compliance with laws, regulations, and provisions of contracts or grant agreements that could have a material effect on each of its federal programs;

(3) Prepare appropriate financial statements, including a schedule of expenditures of federal awards;

(4) Incorporate OMB Circular A-133 audit requirements into all agreements between the Contractor and its Subcontractors who are subrecipients;

(5) Comply with any future amendments to OMB Circular A-133 and any successor or replacement Circular or regulation;

(6) Comply with the applicable requirements of OMB Circular A-87 and any future amendments to OMB Circular A-87, and any successor or replacement Circular or regulation; and

(7) Comply with the Omnibus Crime Control and Safe streets Act of 1968, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, Title IX of the Education Amendments of 1972, The Age Discrimination Act of 1975, and The Department of Justice Non-Discrimination Regulations, 28 C.F.R. Part 42, Subparts C.D.E. and G, and 28 C.F.R. Part 35 and 39. (Go to www.ojp.usdoj.gov/ocr/ for additional information and access to the aforementioned Federal laws and regulations.)

b. Single Audit Act Compliance. If the Contractor is a subrecipient and expends $500,000 or more in federal awards from any and/or all sources in any fiscal year, the Contractor shall procure and pay for a single audit or a program-specific audit for that fiscal year. Upon completion of each audit, the Contractor shall:

(1) Submit to the DSHS contact person the data collection form and reporting package specified in OMB Circular A-133, reports required by the program-specific audit guide (if applicable), and a copy of any management letters issued by the auditor;

(2) Follow-up and develop corrective action for all audit findings; in accordance with OMB Circular A-133, prepare a "Summary Schedule of Prior Audit Findings."

c. Overpayments. If it is determined by DSHS, or during the course of a required audit, that the Contractor has been paid unallowable costs under this or any Program Agreement, DSHS may require the Contractor to reimburse DSHS in accordance with OMB Circular A-87.

21. Termination.

a. Default. If for any cause, either party fails to fulfill its obligations under this Agreement in a timely and proper manner, or if either party violates any of the terms and conditions contained in this Agreement, then the aggrieved party will give the other party written notice of such failure or violation. The responsible party will be given 15 working days to correct the violation or failure. If the failure or violation is not corrected, this Agreement may be terminated immediately by written notice from the aggrieved party to the other party.

b. Convenience. Either party may terminate this Interlocal Agreement for any other reason by providing 30 calendar days' written notice to the other party.

c. Payment for Performance. If this Interlocal Agreement is terminated for any reason, DSHS shall only pay for performance rendered or costs incurred in accordance with the terms of this Agreement and prior to the effective date of termination.

22. Treatment of Client Property. Unless otherwise provided, the Contractor shall ensure that any adult client receiving services from the Contractor has unrestricted access to the client's personal property. The Contractor shall not interfere with any adult client's ownership, possession, or use of the client's property. The Contractor shall provide clients under age eighteen (18) with reasonable access to their

personal property that is appropriate to the client's age, development, and needs. Upon termination of the Contract, the Contractor shall immediately release to the client and/or the client's guardian or custodian all of the client's personal property.

Special Terms and Conditions

1. Definitions. The words and phrases below that are specific to this Agreement shall have the following definitions:

a. "ABCD" means the Access to Baby & Child Dentistry Medicaid–covered program.

b. "A19-1A or A19-1A Invoice Voucher" means the State of Washington Invoice Voucher A19-1A.

c. "CMS" means the U.S. Department of Health & Human Services (HHS), Centers for Medicare & Medicaid Services.

d. "CMS Guide" means the Medicaid School-Based Administrative Claiming Guide issued May 2003 and produced by CMS, and any supplements, amendments or successor; incorporated herein by reference into this Agreement.

e. "CMS SPMP Guide" means the Title XIX Financial Management Review Guide, # 1: Skilled Professional Medical Personnel.

f. "Cognizant Agency" means the agency responsible for reviewing, negotiating, and approving Indirect Cost Rate of the Contractor under OMB Circulars.

g. "Contractor" or "DOH" means the Washington State Department of Health.

h. "DOH Program Administrator" named on Page 1 of this Agreement, means a staff person appointed by the Contractor to be the liaison to the HRSA MAM office for the MAM program.

i. "EPSDT" means the Early Periodic Screening, Diagnosis, and Treatment Program. It is the child health component of Medicaid that is required in every state and is designed to improve the health of low-income children, by financing appropriate and necessary pediatric services.

j. "Family Health Hotline" means a toll-free information line that is operated by WithinReach program staff that performs Medicaid outreach.

k. "FFP" or "Federal Financial Participation" means the federal portion of the total allowable costs of the administrative activities.

l. "Free Care" means services provided to everyone free of charge.

m. "HO" means Healthy Options.

n. "HRSA" means Health and Recovery Services Administration of DSHS.

o. "HRSA Program Manager" means the HRSA contact person named on Page 1 of this Agreement, or successor.

p. "ICM" means Infant Case Management.

q. "Indirect Costs" means costs that are calculated as the direct claimable costs for MAM activities multiplied by the contractor's negotiated indirect rate approved by the Cognizant Agency.

r. "Medicaid Administrative Match (MAM) Activities" or "Medicaid Administrative Activities" means allowable administrative costs directly related to the State Medicaid plan and be found necessary for the proper and efficient administration of the state Medicaid program.

s. "MCO" means Managed Care Organization.

t. "Medicaid" means a joint federal-state program for covered medical services and for costs of administration of related activities.

u. "MMIP" means the Medicare/Medicaid Integration Project.

v. "MER" or "Medicaid Eligibility Rate" means the proportional share of Medicaid individuals to the total number of individuals in the target population.

w. "MSS" means Maternity Support Services.

x. "OMB" means the Federal Office of Management and Budget.

y. "OCRH" means the Office of Community and Rural Health, DOH.

z. "Parallel Coding" refers to a time study coding system, whereby Medicaid activities are distinguished from similar activities that are not Medicaid reimbursable.

aa. "PRAMS" means Pregnancy Risk Assessment Monitoring System.

bb. "PM" means Partial Medicaid, or the proportional share attributable to Medicaid based on the MER.

cc. "PRN" means Perinatal Regional Network.

dd. "R" is a time study code that means Reallocated; time spent on those activities which are reallocated across other codes based on the percentage of all other time spent on allowable/unallowable administrative activities.

ee. "RDA" means Research and Data Analysis, a Division of DSHS.

ff. "SPMP" means Skilled Professional Medical Personnel.

gg. "State Match" means the Contractor's portion of the costs of the administrative activities.

hh. "TM" is a time study code that means Total Medicaid, or 100 percent Medicaid share; a TM administrative activity is wholly attributable to the Medicaid program and as such is not subject to discounting by applying the MER.

ii. "Training Documentation" means signed attendance sheets, or other documentation, showing that staff has received MAM training.

jj. "U" is a time study code that means Unallowable. Time spent on an unallowable activity is not an allowable/reimbursable MAM activity under the Medicaid program.

kk. "WMIP" means the Washington Medicaid Integration Project.

ll. "WIC" means the Supplemental Nutrition Program for Women, Infants and Children.

2. Purpose and Overview of this Interlocal Agreement.

HRSA and the Contractor shall have joint responsibilities and/or coordination requirements in operating

the programs and activities listed and described in this Agreement.

a. Purpose

(1) This Agreement, pursuant to Chapter 39.34 RCW and all relevant and associated statutes, is made and entered into by and between HRSA and the DOH, hereafter referred to as the Contractor. For purposes of this Agreement, the Contractor is a sub recipient of federal awards as defined by the Office of Management and Budget (OMB) Circular A-133. The federal award under this Agreement is made under the Medicaid: Title XIX, Catalog of Federal Domestic Assistance programs No. 93.778. All DOH programs, including Title V funded programs included in this Agreement support the goals of the Medicaid State Plan. The Contractor is authorized under Attachment 4.16-A of the State Plan under Title XIX of the Social Security Act and 42 CFR 431.615 to claim FFP for proper and efficient Medicaid administrative activities that are conducted in support of the State Medicaid Plan utilizing the Contractor's established capacity, infrastructure and programs to assist HRSA in this purpose.

(2) The Contractor shall furnish the necessary personnel and/or services and otherwise do all things necessary for or incidental to the performance of work set forth in this Agreement. Unless otherwise specified, the Contractor shall be responsible for performing all fiscal and program responsibilities as set forth in this Agreement.

(3) HRSA and the Contractor have worked together collaboratively in order to support the goals of the Washington State Medicaid Plan since the late 1980's. This working relationship is intended to:

(a) Improve the quality of Medicaid-related health services available to eligible Washington State citizens by providing medically-related technical expertise and support to HRSA staff and the Contractor's program staff statewide for the purpose of Medicaid program planning and policy development;

(b) Increase accessibility and enrollment of eligible Washington State citizens into needed Medicaid services, thereby improving Medicaid-related health outcomes;

(c) Improve Medicaid-related health outcomes through retaining and recruiting activities intended to maintain and/or increase the number of Medicaid providers available in underserved areas of the State willing to serve Medicaid-eligible citizens; and

(d) Reimburse the Contractor for a portion of the expenses incurred when performing Medicaid administrative activities as described in this Agreement.

b. Medicaid Administrative Match (MAM) Overview

(1) The Contractor shall abide by all of the following MAM claiming guidelines as described and defined in this Agreement.

MAM is a federal program that reimburses the costs of "Administrative Activities" that directly support efforts to identify, and/or enroll children/individuals in the Medicaid program or to assist those already enrolled in Medicaid in accessing benefits. The overarching policy for MAM is that allowable administrative costs must be directly related to a State Medicaid plan or waiver service and be "found necessary for the proper and efficient administration of the state Medicaid Plan."

(2) Examples of eligible, reimbursable MAM activities include:

- Medicaid-related outreach activities;
- Medicaid-related referral and linkage activities;
- Facilitating Medicaid eligibility determinations;
- Medicaid-related program planning and policy development;
- Medicaid-related training.

In 2003, the Centers for Medicare & Medicaid Services (CMS) produced the "Medicaid School-Based Administrative Claiming Guide" (The CMS Guide can be found on the HRSA MAM website at: *http://fortress.wa.gov/dshs/maa/mam*. This CMS Guide is the only MAM guide that has been produced by CMS, and is intended to be applicable to all MAM programs. The Contractor shall reference the CMS Guide, or successor Guides as needed to ensure program activities are in compliance with federal guidelines.

In summary, the CMS Guide:

- Provides a framework for States to use when implementing MAM programs;
- Provides guidelines for preparation of appropriate claims for MAM;
- Ensures reimbursement/payment is for appropriate activities which support effective and efficient administration of the state Medicaid plan;
- Promotes flexibility for program development and implementation;
- Ensures consistency with application of MAM requirements across regions and states;
- Assists with implementation of operational and oversight functions; and
- Provides technical assistance.

c. Principles of MAM Claiming

The Contractor shall abide by the following MAM Program Principles (See the CMS Guide on the HRSA MAM website at http://fortress.wa.gov/dshs/maa/mam for a detailed description of MAM Program Principles):

- All staff participating in MAM and billing for activities must complete the CMS approved time study.
- Proper and efficient administration: the activities must support the Medicaid State Plan.
- Monitoring for the potential of "duplicative" payments will occur.
- Coordination of activities between agencies, governmental entities, State Medicaid agency, providers, community non-profits and other agencies related to activities performed is expected and encouraged.
- As applicable, there will be clear delineation between direct services and administrative activities.
- All Contractor staff participating in the time study must adhere to the principles of parallel coding; Contractor staff must track Medicaid and non-Medicaid activities performed.
- Allocable share of costs (The proportional share of FFP based on the Medicaid Eligibility Rate (MER) will be used as appropriate, and as approved by CMS.
- Provider participation (Medicaid) referrals must be to a Medicaid provider.
- Free care principle precludes Medicaid from paying for the costs of Medicaid covered services and activities which are generally available to all without charge (Title V programs are exempt from this requirement).

- Targeted Case Management: a Contractor may not claim the same costs as both targeted case management and administrative case management.

d. Federal Financial Participation (FFP)

(1) The Contractor shall ensure that its monetary share of costs for Medicaid administrative activities is non-federal, or that they are funds allowable as state match by regulation, and which has not been used and will not be used as match for other federal money.

(2) The Contractor shall not be reimbursed more than the actual costs incurred by that program or claiming unit. In the event the Contractor receives funds that are earmarked for outreach services for Medicaid, or for other administrative activities claimed under MAM, such funds shall be offset from the Medicaid administrative reimbursements.

(3) The Contractor may claim FFP for salaries, benefits, goods & services, travel, indirect costs, and related expenditures for conducting MAM activities described in this Agreement per the MAM principles and requirements set forth in this Agreement, and shall abide by all of the following:

(a) A program activity marked as **Total Medicaid (TM)** is entirely related to administration of the Medicaid program and is 100 percent allowable as administration under the Medicaid program. These activities are not subject to a Medicaid Eligibility Rate (MER).

(b) A program activity marked as **Partial Medicaid (PM)** is the proportional share allowable as administration under the Medicaid program, but costs must be multiplied by the MER. Programs using activities requiring a MER will also designate what comprises the MER (e.g. Medicaid eligible births in Washington State).

(c) A program activity marked as **Unallowable (U)** is unallowable as administration under the Medicaid program.

(d) A program activity marked as **Reallocated (R),** otherwise referred to as Code 10 is reallocated across other codes based on the percentage of time spent on allowable/unallowable administrative activities.

(4) Under the terms of this Agreement, two FFP rates are allowable:

- **50 percent**: Refers to an activity that is allowable under the Medicaid program and claimable at the 50 percent non-enhanced FFP rate.
- **75 percent**: Refers to an SPMP activity that is allowable under the Medicaid program and claimable at the 75 percent enhanced FFP rate. (See Section 7, SPMP Claiming).

3. Statement of Work.

Health and Recovery Services Administration (HRSA) and the Contractor (DOH) Agreement: Medicaid Administrative Match (MAM) Claiming and Cost Allocation Plan (CAP).

a. Time Study Methodology

The Contractor and all sub-contractor staff claiming FFP as described in this Agreement must complete a 100% time study each quarter (See Exhibit B. Semi-monthly Time Sheet).

Special Note: For an exception to the time study methodology, see Section 3. Statement of Work,

c. (3) Within Reach Program.

Contractor's participating staff document 100% of their time during the time study. To meet the CMS requirement of Parallel Coding, Medicaid and non-Medicaid activity codes shall be recorded by staff using the semi-monthly time sheet. Staff shall document all activities completed during each working day, from the beginning to end of each Medicaid and non-Medicaid activity, thus effectively allocating total staff time by both Medicaid and non-Medicaid activities. On the time sheet, staff must provide a brief written description of all MAM activities performed. Staff shall certify, via their personal signature, that each time sheet was completed accurately and appropriately to the best of their knowledge. The Contractor shall be responsible for maintaining time study documentation including assurance that sub-contractors maintain participating staff documentation.

(1) Each time sheet must:

(a) Be completed daily;

(b) Account for the total activity for which each employee is compensated;

(c) Reflect a distribution of the actual activities of each employee; and

(d) Be signed by the employee and the responsible supervisory official who has first hand knowledge of the activities performed by the employee.

(2) All participating staff shall receive time study training annually and retain documentation of successful training completion. It is expected that participating staff will:

(a) Understand how to complete the semi-monthly time sheet;

(b) Know how to report activities under the appropriate time study code;

(c) Understand the difference between health-related and other activities;

(d) Know the distinctions between the performance of administrative activities and providing direct services; and

(e) Know where to obtain technical assistance if he or she has questions.

b. Contractor Program Participation

(1) Any Contractor program, or its sub-contractors, may participate in this Agreement under the following conditions:

(a) Program or subcontractor staff performs MAM activities described in this Agreement;

(b) The MAM activities performed are not included as part of a direct service, and are not reimbursed as such;

(c) CMS authorizes the program's participation;

(d) All participating staff must complete the required time study and document activities performed, and otherwise abide by all terms of this Agreement;

(e) The Agreement must be amended by HRSA and approved by CMS as applicable, if other Contractor programs wish to participate in this Agreement; or, if participating programs develop new methodologies for determining the MER; and

(f) Duplicate payment for activities will not occur. Participating staff must not receive federal reimbursement for MAM activities documented and reimbursed through another MAM Agreement (e.g., Local Health Jurisdiction MAM Agreement).

(2) The Contractor shall also maintain for review as requested by HRSA and/or CMS staff the following:

(a) Documentation to verify the MER for participating programs;

(b) Training, Time Study and Billing documentation;

(c) Staff qualifications and job descriptions (Also see Section 7. SPMP, Claiming).

c. Contractor Program Information

For each participating Contractor program, this section is intended to provide: 1) a brief description; 2) the primary population served; 3) the MER calculation; and 4) the primary MAM activities expected to be performed. (See Section 4, Activity Codes, for the complete list of all Medicaid and non-Medicaid activity codes available for each program during the time study).

(1) Contract Management

DOH Program Administrator: Johanna Flynn or designee/successor, Phone: (360) 236-3508
HRSA MAM Program Manager: Todd Slettvet or designee/successor, Phone: (360) 725-1626

(a) **Program Description**: The DOH Program Administrator shall provide general oversight on all aspects of the development of this Agreement, including successors/amendments and the training of program staff on all time study and activity code requirements. The DOH Program Administrator shall provide technical assistance as needed to staff and assure compliance with the tasks and responsibilities as outlined within this Agreement. This position will communicate and coordinate among participating Contractor's offices and divisions as well as with HRSA as required/needed.

i. Primary MAM activities performed: The DOH Program Administrator shall perform all of the activities described below, and code these activities using Code 12.b.

(A) Be familiar with all aspects of this Agreement in order to serve as the primary liaison to the HRSA MAM Program Manager.

(B) Respond to all requests from the HRSA MAM Program Manager pertaining to the implementation and development of this Agreement, including but not limited to participation in monitoring activities, training activities, planning meetings, developing amendments, and gathering/providing information and documentation as requested by HRSA or CMS staff.

(C) Provide Agreement oversight, training and technical expertise for participating staff/programs concerning the MAM time study and activity code methodology.

(D) Assist as needed with billing and/or claiming procedures as described in this Agreement.

(E) Consult as needed with the HRSA MAM Program Manager on all aspects pertaining to this Agreement.

ii. The DOH Program Administrator shall:

(A) Ensure that all MAM training materials are first approved by the HRSA Program Manager (e-mail authorization is sufficient).

(B) Receive prior to the execution of this Agreement MAM Coordinator training from the HRSA MAM Program Manager, including "refresher" training each contract year or as deemed necessary.

(C) Document that all participating staff receive MAM training prior to participation in the time study, as well as refresher training once every four quarters.

(b) **Population Served**: The DOH Program Administrator supports all Contractor programs participating in this Agreement.

(c) **MER**: In the interests of economy and efficiency, CMS is not requesting that a MER be developed for this "program". The costs to be claimed for this position are minimal, and the costs of the effort to develop a MER would be excessive compared to the dollar amount of costs to be allocated. Therefore, 100% of the designated Contractor Program Administrator's time allocated to Code 12.b. MAM activities as described above will be reimbursed at 50% FFP.

(2) Office of Community and Rural Health (OCRH)

DOH Contacts:	Kris Sparks, or designee/successor, Phone: (360) 236-2805
	Diana Ehri, or designee/successor, Phone: (360) 236-2813
HRSA Contacts:	Michael Paulson, or designee/successor, Phone: (360) 725-1641
	Dr. John Davis, or designee/successor, Phone: (360) 725-1748

(a) **Program Description**: The OCRH within the DOH coordinates outreach activities with HRSA and others to secure recruitment and retention of sufficient health care personnel to facilitate provider access for Medicaid and Medicaid eligible people. In addition, OCRH coordinates with DOH, HRSA and others on analysis of Medicaid access and reimbursement issues.

i. Primary MAM activities performed by OCRH. The Contractor shall:

(A) Evaluate the need for medical, dental, and mental health services for Medicaid and Medicaid eligible people. Each analysis specifically identifies the current number of health care personnel in Washington State and the number of Medicaid clients served, (Code 7.b.);

(B) Identify and share with HRSA Medicaid reimbursement or policy issues impacting health care personnel, (Code 7.b.);

(C) Analyze data related to Medicaid clients' access to health services, their needs, and

quality of care, costs and reimbursement issues. Data is generated from health care personnel with Medicaid core provider agreements, and state, federal and other reputable resources (e.g. University of Washington and Rural Research Centers), (Code 7.b.);

(D) Identify and recruit health care personnel to rural and underserved areas of the state. Health care personnel are expected to be Medicaid core health care providers. Recruitment efforts focus on health care personnel who serve or will serve Medicaid and Medicaid eligible people. All recruited health care personnel are given assistance to become a Medicaid core provider. Work with Medicaid health care personnel to understand necessary requirements for billing, policy or program changes, (Code 11.b.);

(E) Provide assistance to health care facilities to improve access for Medicaid and Medicaid eligible populations. All facilities are expected to participate as Medicaid health care providers, (Code 11.b.); and

(F) Assist health care facilities to get a Medicaid core provider agreement in place. Work with Medicaid facilities to understand necessary requirements for billing, policy or program changes, (Code 11.b.).

ii. OCRH Deliverables. Quarterly, the Contractor shall:

(A) Share the Health Professional Shortage Areas listing with the HRSA Contacts;

(B) Provide a description of any identified reimbursement or policy issues impacting Medicaid provider placement/medical facilities;

(C) Share Medicaid-related fact sheets with the HRSA Contacts detailing population demographics and other relevant data and related reports;

(D) Provide the HRSA Contacts with the names of all Medicaid health care providers recruited; and

(E) Provide the HRSA Contacts with the names of the facilities where Medicaid health care providers are placed.

iii. Primary MAM activities performed by Area Health Education Center (AHEC) staff. The Contractor shall:

(A) Perform a needs assessment for medical, dental, and mental health services for Medicaid and Medicaid eligible people in rural and underserved areas, (Code 7.b.);

(B) Identify and share with HRSA Contacts Medicaid reimbursement or policy issues impacting health care personnel, (Code 7.b.);

(C) Identify and recruit health care personnel to rural and underserved areas of the state. Health care personnel are expected to be Medicaid core health care personnel. Recruitment efforts focus on health care personnel who serve or will serve Medicaid and Medicaid eligible people. All recruited health care personnel are given assistance to become a Medicaid core provider, (Code 11.b.);

(D) Work with Medicaid health care personnel to understand necessary requirements for billing, policy or program changes, (Code 11.b.);

(E) Provide assistance to health care facilities to improve access for Medicaid and Medicaid eligible populations. All facilities are expected to participate as Medicaid health care personnel. Assist health care facilities to get a Medicaid provider agreement in place. Work with Medicaid facilities to understand necessary requirements for billing, policy or program changes, (Code 11.b.); and

(F) Increase access to services for Medicaid and Medicaid eligible patients through the placement of health professions students in Medicaid provider sites, for clinical experiences, (Code 11.b.).

iv. AHEC Deliverables. The Contractor shall:

(A) Bi-annually, share the needs assessments with the HRSA Contacts;

(B) Bi-annually, provide a description of any identified reimbursement or policy issues impacting Medicaid provider placement/medical facilities;

(C) Quarterly, provide the HRSA Contacts with the names of all Medicaid health care providers recruited;

(D) Quarterly, provide the HRSA Contacts with the names of the facilities where Medicaid health care providers are placed; and

(E) Quarterly, provide HRSA with a list of all Medicaid health care providers used to provide clinical experiences in rural and underserved areas of Washington State.

(b) **Population Served:** Rural and urban medically underserved communities in Washington State.

(c) **MER:** The MER will be developed each quarter. All MAM activities requiring a MER (OCRH and AHECs) will use the percentage of total health care professional positions filled that have signed a core provider agreement with HRSA. Example: 20 health care personnel "positions" were recruited during the first quarter. Of those 20 positions, 18 have signed a Medicaid core provider agreement. The MER is 18/20 or 90%.

(3) WithinReach

DOH Contacts:	Marilyn Gisser or designee/successor, Phone: (360) 236-3503
	Kathy Chapman or designee/successor, Phone: (360) 236-3968
	Kristin Sasseen or designee/successor, Phone: (360) 236-3633
HRSA Contact:	Carole McRae or designee/successor, Phone: (360) 725-1250

(a) **Program Description**: The Contractor subcontracts with WithinReach to do MAM activities. Activities are targeted to Medicaid eligible pregnant women, children and families to provide information about Medicaid eligibility and Medicaid programs. WithinReach encourages potential eligibles to apply for Medicaid and assists users in generating and submitting Medicaid applications.

i. Primary MAM activities performed by WithinReach staff. The Contractor shall:

(A) Inform Medicaid eligible and potentially eligible individuals and families about the benefits, and availability of Medicaid-covered services, (Code 1.b.);

(B) Encourage individuals and families to access services provided by the Medicaid program, (Code 1.b.);

(C) Provide information about the First Steps program, Medicaid, and EPSDT and encourage callers and website users to be screened and to receive preventive prenatal and/or well child care, including immunizations and other preventive services covered by Medicaid, (Code 1.b.);

(D) Provide health information and information about Medicaid-covered programs and services in their communities, (Code 1.b.);

(E) Distribute Medicaid enrollment forms to callers as appropriate, either hard copies or by directing them to the website, (Code 1.b.);

(F) Develop outreach materials, (Code 1.b.); and

(G) Provide information and referrals to callers about WIC Services, (Code 1.b.). **(See Special Note below regarding WIC referrals.)**

ii. Primary MAM activities performed by DOH program staff. The Contractor shall:

(A) Conduct appropriate research and evaluation activities to assure quality of Medicaid-related information provided to callers and website users, (Code 7.b.);

(B) Participate in training on administrative requirements related to Medicaid services, (Code 8.b.);

(C) Conduct administrative oversight of the WithinReach sub-contract which is exclusively dedicated to Medicaid activities, (Code 7.b.).

iii. Direct Costs:

With the goal of directing potential eligibles to enroll in Medicaid, publicize WithinReach in order to encourage potential Medicaid applicants to call the **Family Health Hotline** for more information. Medicaid outreach expenditures for printing and mailing costs may be claimed as “Goods & Services”. No MER is applied when advertising costs do not also include other programs/funding sources. An example of the reimbursement calculation would be:

$1000.00 (Total Costs) x 50% FFP = $500.00 Medicaid Share

Direct costs of administering the call center, including phone line fees and equipment, will be allocated using/based on the statistics/percentages derived from the Semi-monthly Tally Sheet (See Exhibit C. Tally Sheet) as documented by helpline staff, and described below under Time Study Description. The total percentage of calls each month that is determined to be Medicaid outreach will serve as the Medicaid allocation of direct charges related to operating the hotlines.

Special Note: HRSA agrees to allow WithinReach staff to claim MAM for “providing

information and referrals to callers about WIC Services as Code 1.b." with the understanding that all Washington State WIC agencies are required by federal regulation and state policy to provide WIC participants with written information about the Medicaid program and to refer individuals not currently participating in Medicaid to the Medicaid program for services. These requirements and actions are part of usual and required WIC procedures and are covered as part of WIC allowable costs. Local WIC staff/programs shall not claim MAM for providing information and referrals about Medicaid services to WIC participants.

iv. Deliverables:

(A) Quarterly, WithinReach will provide the HRSA contact with a report detailing the total number of telephone contacts.

(B) If Title XIX funds are used to support the website, the HRSA Contact will receive a quarterly report detailing the total number of website hits.

(C) The HRSA Contact shall review and approve in writing, or via e-mail, all Title XIX-funded outreach materials/resources used by WithinReach to publicize the Family Health Hotline and interactive website. The review by HRSA Contact shall be completed within 2 weeks of receiving draft materials.

(b) **Population Served**: Washington State families; efforts are targeted to Medicaid-eligible pregnant women, children, and families.

(c) **Time Study Description**: Contractor and WithinReach staff that do not operate the phone lines and participate in Title XIX funded activities will use the regular time study methodology described in this Agreement.

For WithinReach phone staff, a tally sheet entry for each phone call will serve as the time study methodology. This database-driven tally sheet will be maintained on a day-to-day basis by individual phone staff and will be used to allocate Medicaid outreach costs. (Because the "Family Planning/Take Charge" phone line is also being matched by Title XIX, staff shall only check Medicaid **OR** Take Charge for one phone call, if applicable, never both. The total percentage of calls each month that is determined to be dedicated to Medicaid outreach via the tally sheet, will serve as the Medicaid allocation of "phone staff" time.

Example: If a phone staff's tally sheet data shows that 50% of his or her time on the phone is spent doing Medicaid outreach (Family Health Hotline) each month, and the rest of the staff's time is spent as follows: 10% Take Charge; 20% Basic Food; and 20% SCHIP; then 50% of this phone staff's salary that month is reimbursable at a 50% FFP.

A sample reimbursement calculation for WithinReach phone staff would be as follows:

Staff salary for the quarter = $10,000

Tally Sheet data shows that 50% of all calls are Medicaid outreach dedicated to the Family Health Hotline

$10,000 x 50% Medicaid outreach = $5,000 allocated to Medicaid outreach

Medicaid outreach costs = $5,000 x 50% FFP = $2,500 reimbursement

Staff at WithinReach that do not answer phones and participate in Title XIX funded activities may also claim MAM. These staff shall complete the 100% time study as described in this Agreement.

(d) **MER**: There are three methodologies for calculating the MER for WithinReach:

i. WithinReach "phone staff" shall not use a MER. 100% of phone staff time allocated to Medicaid outreach, as determined by the Tally Sheet, shall be reimbursed at 50% FFP.

ii. WithinReach staff that is not phone staff shall use the percent of calls, as determined by the Tally Sheet to be Medicaid, as the MER.

iii. The MER for DOH staff shall be 100%. The program being administered is dedicated to Medicaid outreach, and there is not a specific population being served.

(4) HIV/AIDS Targeted Case Management

DOH Contact: Monique Ossa, or designee/successor, Phone: (360) 236-3457
HRSA Contact: Maureen Lally, or designee/successor, Phone: (360) 725-1655

(a) **Program Description**: Administrative support and oversight of HIV case management services, a covered service in the State Medicaid Plan. The DOH contact for this program shall be the only staff claiming MAM for the activities described below:

i. Primary MAM activities performed. The Contractor shall:

(A) Provide technical and capacity development assistance to potential/current providers, (Code 7.b.);

(B) Review Title XIX HIV/AIDS Case Management provider applications and forward to HRSA for contract processing, (Code 7.b.);

(C) Maintain policies and procedures for the daily operations of the Title XIX HIV/AIDS Case Management Program, including, but not limited to: recommending payment rates; monitoring provider compliance with established scope of services and standards of service delivery, (Code 7.b.);

(D) Provide quality assurance activities/measures, including technical assistance to Title XIX HIV/AIDS populations through training of providers, access to clinical consultation and development of continuing quality improvement plans, (Code 7.b.);

(E) Facilitate the smooth transition to Medicaid services for eligible HIV/AIDS populations through assuring coordination of services to these populations, (Code 7.b.); and

ii. Deliverables:

(A) Annually, the Contractor shall provide the number and results of monitoring visits to the HRSA Contact.

(B) Annually, the Contractor shall provide the number of providers enrolled to the HRSA Contact.

(C) Annually, the Contractor shall provide the number of "technical assistance and training activities" given to providers, including the names of providers.

(D) The Contractor shall share training materials with the HRSA Contact as they are developed.

(b) **Population Served:** Medicaid eligible individuals with HIV/AIDS.

(c) **MER:** Clients enrolled in this program must be enrolled in Medicaid, thus the MER is 100%. All staff time allocated to MAM activities under "HIV/AIDS Targeted Case Management" will be reimbursed at 50% FFP.

(5) Newborn Screening

DOH Contacts: Mike Glass, or designee/successor, Phone: (206) 418-5470
Sheila Weiss, or designee/successor, Phone: (206) 418-5509
HRSA Contact: Sharon Reddick, or designee/successor, Phone: (360) 725-1656

(a) **Program Description**: The Newborn Screening program performs administrative activities to assure Medicaid clients with Phenylketonuria (PKU), and other disorders specified by the State Board of Health in Chapter 246-650 WAC *(Newborn Screening)* are receiving appropriate long-term specialty clinical care services needed to avoid the harmful effects of the disorders. Any direct services (e.g. delivering PKU formula) shall be funded through fees charged to hospitals, third party payers, and families.

i. Direct services the Contractor shall provide include:

(A) Laboratory testing for all conditions specified by the State Board of Health.

(B) Reporting laboratory results to hospital, clinic or provider that submitted the specimen.

(C) Follow-up to assure that appropriate actions are taken in response to test results.

(D) Purchase and storage of metabolic treatment products.

(E) Distribution of products to patients as directed by their care provider.

ii. Primary MAM activities performed. The Contractor shall:

(A) Refer eligible clients for prompt medically-related diagnostic and treatment services, (Code 9.b.);

(B) Provide outreach to affected families to inform them about Medicaid covered services for which they may be eligible, (Code 1.b.);

(C) Facilitate Medicaid eligibility determinations, (Code 2.b.);

(D) Assist with Medicaid transportation, (Code 5.b.);

(E) Monitor activities with providers/clients/families to ensure follow through with medically-related diagnostic and treatment services, (Code 9.b.); and

(F) Coordinate activities/meetings with local health departments, provider clinics, University of Washington, Biochemical Genetics Clinic, and/or other systems or service providers to improve the delivery and authorization of Medicaid covered services, (Code 7.b.).

iii. Deliverables. The Contractor shall:

(A) Provide a quarterly report to the HRSA Contact of the total number of clients served. The report shall include details such as the number of clients by county, age (infant/child/adult), and by service provided.

(B) Participate in two annual meetings with the HRSA Contact to coordinate activities and ensure the Newborn Screening program continues to support the goals of Medicaid.

(C) Be available to provide a yearly, brief Newborn Screening training segment to managed care plans as mutually arranged by DOH and HRSA.

(b) **Population Served:** Newborns and their families.

(c) **MER:** There shall be two MERs used each billing quarter:

i. One MER shall be determined by the percent of Medicaid eligible "newborns" in the state of Washington**.** Using the First Steps database, or other similar source, this MER will be determined by tracking all births in Washington State and determining the percentage of those births that are Medicaid. (Newborns are one population served by this program).

ii. The second MER will be determined by the percent of Medicaid eligible clients (not newborns) served, divided by the total number of clients (not newborns) served.

Special Note: The Contractor shall track activities quarterly, by population served, to ensure that the appropriate MER will be used.

(6) First Steps

DOH Contact:	Kathy Chapman or designee/successor, Phone: (360) 236-3968
HRSA Contacts:	Maureen Lally or designee/successor, Phone: (360) 725-1655
	Dr. Nancy Anderson or designee/successor, Phone: (360) 725-1751

(a) **Program Description:** The First Steps program provides enhanced support services to Medicaid enrolled pregnant women through the maternity cycle (Maternity Support Services) and for eligible families through the month of the infant's first birthday (Infant Case Management). Interventions are performed as early in a pregnancy as possible to promote a healthy pregnancy and positive birth and parenting outcomes. Once the infant is born, targeted case management services improve birthparent (and family) self-sufficiency in accessing social and health resources to meet immediate needs. The State Medicaid Plan includes extended services for pregnant women through sixty days postpartum and targeted case management services for high risk Medicaid eligible infants. The Contractor and HRSA shall approve First Steps providers. First Steps provider services include:

- Psychosocial assessment and/or counseling visits;
- Nursing assessment and/or counseling visits;
- Nutrition assessment and/or counseling visits;
- Community health worker visits;
- Childbirth education; and
- Smoking cessation counseling that includes assessing the pregnant and postpartum woman's tobacco dependence.

i. Primary MAM activities include:

(A) The Contractor shall assist HRSA in administering the First Steps Maternity Support Services (MSS), Infant Case Management (ICM) and Childbirth Education (CBE) programs, (Code 7.b.). Sample activities performed include:

- Identify gaps or duplication of services and develop strategies to improve the delivery and coordination of MSS/ICM and CBE.
- Develop strategies to increase capacity of MSS/ICM and CBE in underserved areas.
- Convene/participate in consultation meetings, interagency work groups, and planning activities that impact Medicaid service delivery and access to care, MSS/ICM and issues related to maternity access.
- Coordinate/collaborate, analyze data, etc. for improved service delivery; program planning, policy development, information sharing, evaluation and administrative decisions.
- Assure consistent communication of program requirements and other relevant information with providers using varied communication venues and tools.
- Respond to inquiries from stakeholders, including providers, the public, the legislative and/or executive branches, and others concerning MSS/ICM and CBE.

(B) The Contractor shall provide clinical oversight/monitoring of Medicaid programs to assure quality of care, medical necessity and compliance with medically-related requirements, including corrective action and/or technical assistance, (Code 7.d.).

(C) The Contractor shall update the WAC, billing instructions, relevant contracts or other official agreements, manual and other program publications, (Code 7.b.).

(D) The Contractor shall participate in the development, delivery and/or coordination of training that improves the delivery of MSS, ICM, CBE, and Medicaid related services, (Code 8.b.).

(E) The Contractor shall provide technical expertise and support to HRSA staff including participation in training on administrative requirements related to Medicaid services, (Code 8.b.).

Special Note: Any Contractor staff time spent working on First Steps program or policy issues pertaining to undocumented aliens will not be claimed as MAM. This activity will be coded as Code 7.a.

ii. Deliverables. The Contractor shall submit:

A written quarterly report to the HRSA Contact within 20 business days after each

quarter ends. The report will describe products and activities completed during the quarter. The report will include an update of the following activities:

(A) Monitoring;

(B) Status of special projects;

(C) Communication activities; and

(D) Training.

(b) **Population Served**: Pregnant and post partum Medicaid eligible women and families; high risk Medicaid eligible infants and their biological parents.

(c) **MER**: Women enrolled in First Steps (MSS and ICM) must be enrolled in Medicaid, thus the MER is 100%. Staff time allocated to MAM activities under "First Steps" will be reimbursed at 50% FFP, or at 75% FFP for allowable SPMP activities.

(7) Tobacco Prevention and Control Program

DOH Contacts:	Juliet Thompson, or designee/successor, Phone: (360) 236-3733
	Suzette Vik, or designee/successor, Phone: (360) 236-3625
HRSA Contacts:	Maureen Lally, or designee/successor, Phone: (360) 725-1655
	Dr. Nancy Anderson, or designee/successor, Phone: (360) 725-1751

(a) **Program Description:** In collaboration with DOH Tobacco Program, Maternity Infant Health (MIH) and HRSA, the Contractor shall develop, implement and provide oversight to initiatives aimed at reducing and/or eliminating tobacco usage and second hand smoke exposure in Medicaid populations, including the MSS/ICM Tobacco Cessation Performance Measure requirements, which are in alignment with and support the First Steps Medicaid State Plan.

i. Primary MAM activities performed. The Contractor shall:

(A) Provide annual training to First Steps providers via a Tobacco Cessation Champion Project meeting. Providers who serve Medicaid eligible women in geographic areas impacted by high tobacco usage and exposure will be encouraged to attend, (Code 8.b);

(B) Conduct annual trainings focused on fulfilling the requirements of the First Steps Tobacco Cessation During Pregnancy Performance Measure, (Code 8.b); and

(C) Work with other agencies and providers of services to Medicaid eligibles to improve the coordination and delivery of services and resources focused on tobacco cessation/reduction and second hand smoke exposure, (Code 7.b).

ii. Deliverables. The Contractor shall submit to the HRSA Contact:

(A) An annual Champion Project report including a list of participants with contact information, a copy of the agenda, materials, a summary of the evaluations and outcomes of the agency specific action plans.

(B) An annual First Steps Tobacco Cessation During Pregnancy Performance Measure

report including a list of attendees with contact information, a copy of the agenda, copy of the guidebook, resource materials and a summary of the evaluations.

(C) A quarterly report for the annual report 20 business days after each quarter ends. The HRSA Contact will review the quarterly submissions, to assess project outcomes and recommendations for program change or improvement.

(b) **Population Served**: Medicaid eligible pregnant women and infants.

(c) **MER**: 100% of the designated population is Medicaid eligible. Staff time allocated to MAM activities shall be reimbursed at 50% FFP.

(8) Perinatal Regional Network (PRN)

DOH Contact: Jeanette Zaichkin, or designee/successor, Phone: (360) 236-3582
HRSA Contacts: Maureen Lally, or designee/successor, Phone: (360) 725-1655
Dr. Nancy Anderson, or designee/successor, Phone: (360) 725-1751

(a) **Program Description**: State and regional quality improvement projects contribute to improving pregnancy outcomes, decreasing maternal and infant morbidity and mortality, and decreasing incidence of low birth weight and prematurity. The PRN in each region functions as a work group of health professionals providing assessment of the health delivery system, develop recommendations for improvements to the system, and provide consultation and advice regarding the delivery of health services to pregnant women and newborns. The PRN Manager publishes an annual report and provides consultation to the state Medicaid program regarding recommendations for systems improvements. The PRN coordinators in each region are licensed healthcare professionals with expertise in perinatal and/or neonatal nursing/medicine. The PRN coordinators involve healthcare professionals and public health agencies in quality improvement projects that influence program planning, policy development and interagency coordination.

i. Primary MAM activities performed. The Contractor shall:

(A) Develop strategies to assess and identify perinatal health systems gaps and capacity issues related to medical services for pregnant women and newborns, (Code 7.b);

(B) Collaborate with other agencies and/or providers to enhance the quality and availability of medical services within the state's perinatal health systems serving pregnant women and neonates; develop systems strategies to improve the early identification of medical problems and to help prevent poor birth outcomes, (Code 7.b.);

(C) Provide recommendations directly to HRSA for systems improvements, (Code 7.b.);

(D) Participate in program planning, policy development, and interagency coordination related to Medicaid services, (Code 7.b.); and

(E) Participate in monitoring, consultation, contract management, meetings, workgroups, and planning to improve Medicaid-related outreach, (Code 7.b.).

ii. Deliverables:

(A) The PRN Manager from Maternal and Infant Health shall submit proposed contractual projects to the HRSA Contact for approval, prior to initiating the PRN contracts.

(B) The PRN Manager from Maternal and Infant Health shall submit a quarterly report to the HRSA Contact 20 business days after each quarter ends that describes the progress of the state and regional quality improvement projects, and recommended program modifications and strategies to improve Medicaid services available to pregnant women and infants as. The HRSA Contact shall review quarterly submissions for the annual report to assess project outcomes and recommendations for system change or improvement.

(C) The PRN Manager shall consult with the HRSA Contact regarding implementation of recommendations that directly impact the Medicaid system (example: recommendations for quality improvement for health plans).

(b) **Population Served:** The Perinatal Regional Network (PRN) focuses on improving pregnancy outcomes for Medicaid clients through activities that improve the quality of care at the systems level. For example, in hospitals Medicaid clients are at disproportionately increased risk of adverse pregnancy outcomes.

(c) **MER:** Using the First Steps database, or other similar source, the MER will be determined by tracking all births in Washington State and determining the percentage of those births that are Medicaid. This number is updated annually and shall be submitted to HRSA for review and approval.

(9) Pregnancy Risk Assessment Monitoring System (PRAMS)

DOH Contacts:	Riley Peters, or designee/successor, Phone: (360) 236-3581
	Linda Lohdefinck, or designee/successor Phone: (360) 236-3497
HRSA Contacts:	Maureen Lally, or designee/successor, Phone: (360) 725-1655
	Dr. Nancy Anderson, or designee/successor, Phone: (360) 725-1751
RDA Contact:	Dr. Laurie Cawthon, or designee/successor, Phone: (360) 902-0712

(a) **Program Description:** PRAMS is an on-going, population-based surveillance system sponsored by the Centers for Disease Control and Prevention (CDC) and implemented in Washington State by the state Department of Health. In collaboration with HRSA, PRAMS surveys recently pregnant women, two to six months after delivery, about their pregnancy, individual behaviors, prenatal care, and medical services for themselves and their newborn. PRAMS survey data supplements administrative data and vital statistics records with the perspective of individual pregnant women and assists HRSA in making administrative decisions for Medicaid programs such as First Steps. Especially helpful is data about certain high-risk populations, such as African Americans and Native Americans. The total number of births in these groups is small; however, the majority of pregnant African American and Native American women are served by Medicaid (70.3% and 79.6%, respectively). To obtain valid survey data on these small groups, the PRAMS survey oversamples non-white race/ethnic groups. HRSA is then able to obtain valid data for the relatively small groups who are at high risk of poor birth outcomes and are over-represented in the Medicaid population.

i. Primary MAM activities performed.

The Contractor shall conduct research and evaluation activities for the purpose of Medicaid program planning and policy improvement, (Code 7.b.), including:

- Surveying a random sample of new mothers each month, including over-sampling by race/ethnicity in order to obtain data on high risk populations such as African American, and/or Asian/Pacific Islander, etc.
- Analyzing PRAMS data on maternity outcomes, behaviors, perceptions, and care received. Analyses will include comparisons between Medicaid and non-Medicaid reported information and outcomes.
- Providing PRAMS survey data to HRSA First Steps database in accordance with Institutional Review Board approval to assist with First Steps program planning and evaluation.

ii. Deliverables:

(A) The Department of Social and Health Services, RDA shall provide:

- New contact information for Medicaid mothers to the PRAMS operations staff to facilitate response rates for Medicaid clients; and
- PRAMS staff with Medicaid 2 flag identifying which program each of the Medicaid mothers was enrolled under. (Provision of these data is authorized by the Confidentiality Agreement for the PRAMS project established by the Washington State Institutional Review Board. HRSA contracts separately for RDA's work via a Memorandum of Understanding.)

(B) PRAMS. The Contractor shall:

- Annually provide PRAMS weighted data joined with the Birth Certificate file data to RDA, First Steps Database;
- Submit all reports using PRAMS-Medicaid linked data to RDA for review and comment prior to publishing; and
- Respond to special requests for analysis from First Steps Program and First Steps Database.

(b) **Population Served:** New mothers who delivered a live infant. Over-sampling is conducted for specific populations as indicated in the Program Description above.

(c) **MER:** Medicaid women represent 58.6% of the total women in PRAMS sample, thus the MER used will be 58.6%. The MER will be modified as needed to reflect the appropriate percentage.

(10) Oral Health

DOH Contacts: Dr. Joseli Alves-Dunkerson, or designee/successor, Phone: (360) 236-3524
Dr. Divesh Byrappagari, or designee/successor, Phone: (360) 236-3507
HRSA Contacts: Margaret Wilson, or designee/successor, Phone: (360) 725-1658
Dr. John Davis, or designee/successor, Phone: (360) 725-1748

(a) **Program Description:** The Oral Health program strives to decrease oral health disparities and ensure the availability of dental practitioners to serve the Medicaid population. The program supports access to programs such as "Access to Baby & Child Dentistry" (ABCD),

a Medicaid program. Oral Health program staff participate in planning meetings and provide training, expert consultation and technical expertise to local oral health coordinators that work closely with ABCD. The program also includes an access webpage "How to Find Dental Care" which is part of a collaborative statewide initiative to improve access to dental care for low-income groups. This webpage lists the dental clinics and providers available in each county.

i. Primary MAM activities performed. The Contractor shall:

(A) Plan and coordinate collaborative activities intended to improve access and delivery of Medical and dental services to Medicaid eligible clients, (Code 7.b.);

(B) Collect and analyze data related to oral health programs, populations or geographic areas, oral health status, dental workforce, water fluoridation, school sealants, and gaps in dental access, for the purpose of improving dental services, (Code 7.b.);

(C) Coordinate an access webpage tailored to the Medicaid eligible population, that includes information about county-level public dental clinics and providers including referral networks, (Code 7.b.); and

(D) Provide dental expertise and training to local and state government staff who are not providers of direct services about how to find dental care and make appropriate referrals, (Code 8.b.).

ii. Deliverables. The Contractor shall provide:

(A) Annual Oral Health program reports, to the HRSA Contacts, including a summary of activities focused on improving the access and delivery of medical and dental services to Medicaid eligible clients; updates on data collection and analysis related to oral health issues and the Medicaid population; recent reports from any data analysis; updates on the webpage; and training that has occurred.

(B) Semi-annual meetings with the HRSA Contacts to discuss issues such as Oral Health program activities, quality improvement and current dental practices for the Medicaid eligible population.

(b) **Population Served:** Medicaid eligible infants, children and families throughout Washington State.

(c) **MER:** To be determined annually using data about 0-20 year olds in the state population eligible for Medicaid as well as pregnant women in Washington State who are Medicaid eligible.

(11) CHILD Profile Immunization Program

DOH Contacts: Janna Bardi or designee/successor, Phone: (360) 236-3568
Katherine Harris-Wollburg or designee/successor, Phone: (360) 236-3513
HRSA Contacts: Margaret Wilson or designee/successor, Phone: (360) 725-1658
Bev Atteridge or designee/successor, Phone: (360) 725-1575

(a) **Program Description:** This program performs administrative activities to assure Medicaid

clients receive Early Periodic Screening Diagnosis and Treatment (EPSDT), including immunizations. This program is also responsible for the administration of the federal Vaccines for Children (VFC) program. Medicaid clients are the majority of the VFC eligible population. As the administrators of VFC, this program purchases, distributes, and tracks all routinely recommended vaccines for Medicaid children 0 through 18 years of age. This program assists HRSA in decision making processes regarding assessment, resource allocation, and other administrative activities, to assure Medicaid clients receive EPSDT services and immunizations at the right time. This program manages and operates the statewide CHILD Profile Immunization Registry and Health Promotion system in collaboration with HRSA to assure that:

- Parents have information that supports and assists them in making health care decisions for their children;
- Providers have access to a repository of data to make immunization decisions; and
- The information needed to protect the public from vaccine preventable diseases is readily available.

i. Primary MAM activities performed. The Contractor shall:

(A) Provide reminders to parents to schedule EPSDT visits, including immunizations, for Medicaid eligible and potentially eligible individuals and families, (Code 9.b.);

(B) Provide information about how to seek Medicaid services, (Code 1.b.);

(C) Participate in interagency workgroups with HRSA to provide consultation and engage in planning activities related to increasing EPSDT and immunization completion rates for Medicaid eligible children, (Code 7.b.);

(D) Coordinate and conduct training for, and secure participation agreements from, health care providers and school nurses on use of the CHILD Profile Immunization Registry, to enhance the capacity to assure Medicaid eligible children are age-appropriately immunized, (Code 8.b.); and

(E) Regularly meet with HRSA staff to discuss Medicaid reimbursement policy issues for vaccine and vaccine administration and how those policies impact Medicaid providers, (Code 7.b.).

ii. Deliverables:

(A) The HRSA Contacts shall review and approve all Medicaid outreach materials aimed at increasing EPSDT and immunization completion rates for Medicaid eligible children prior to their use.

(B) The Contractor shall provide quarterly reports to the HRSA Contacts on:

- Participation on inter-agency workgroups aimed at increasing EPSDT and immunization completion rates for Medicaid eligible children;
- The number of school districts and health care providers with fully executed CHILD Profile contracts; and
- The dates of meetings with HRSA staff to discuss policy issues.

(b) **Population Served:** Washington State's children, birth through 18 years old and their parents/guardians and health care providers.

(c) **MER:** The Contractor shall develop annual population estimates to determine the percentage of Medicaid eligible and other VFC eligible populations. The total population of children ages 0 through 18 years (as determined by the Office of Financial Management) is compared proportionately to the unduplicated number of children who are Medicaid eligible (as reported by HRSA). The MER is the percentage of the population served that is Medicaid eligible per this calculation.

(12) Children with Special Health Care Needs Program (CSHCN)

DOH Contact: Maria Nardella or designee/successor, Phone: (360) 236-3573
HRSA Contacts: Sharon Reddick or designee/successor, Phone: (360) 725-1656
Carole McRae or designee/successor, Phone: (360) 725-1250

(a) **Program Description:** The Children with Special Health Care Needs program coordinates outreach, referral, and linkage activities with HRSA and others to stay current on eligibility and benefit issues, to assure they continue to be appropriate for the children with special health care needs population. CSHCN staff use their expertise about this population to participate in HRSA policy development including WACs, billing instructions, gaps in covered services, and HRSA workgroups and committees.

i. Primary MAM activities performed. The Contractor shall:

(A) Inform Medicaid eligible and potentially eligible children with special health care needs and their families about the benefits and availability of Medicaid-covered services, (Code 1.b.);

(B) Use expertise to provide consultation meetings for Local Health Jurisdictions, contractors, work groups comprised of stakeholders; planning to improve medically-related service delivery to Medicaid eligible children with special health care needs; and to refer clients to Medicaid providers, (Code 7.b.);

(C) Serve as liaison with Disabilities Determination Service Division to assist with client eligibility determinations and maintain systematic mechanism for identifying Title V recipients who are potential Supplemental Security Income (SSI) applicants for referral to the Social Security Administration (SSA) and access to Medicaid-covered health care services. Clients receiving SSI are Medicaid eligible, (Code 2.b.);

(D) Assist HRSA in Medicaid policy development including WACs, billing instructions and other workgroups and committees, (Code 7.b.); and

(E) Provide Medicaid-related training activities to CSHCN contractors, partners and stakeholders, (Code 8.b.).

ii. Deliverables: The Contractor shall submit a quarterly summary to the HRSA Contacts listing MAM approved activities that the Contractor performed during the quarter.

(b) **Population Served:** Medicaid eligible children 17 years of age or younger living in Washington State who have, or are at risk for, chronic illnesses and handicapping conditions, including severe health-related educational or behavioral problems.

(c) **MER:** The MER will be determined by using a program database that will provide the percentage of the client population that is Medicaid eligible each quarter.

(13) Genetic Counseling

DOH Contact: Deb Doyle or designee/successor, Phone: (253) 395-6742
HRSA Contact: Bev Atteridge or designee/successor, Phone: (360) 725-1575

(a) **Program Description:** The purpose of the Genetic Counseling program is to improve access to and availability of Medicaid-covered services to eligible clients in need of genetic counseling and related medical services, and to serve as a genetics expert/consultant to HRSA staff.

i. Primary MAM activities performed. The Contractor shall:

(A) Provide expertise, consultation and technical assistance to HRSA staff, medical providers and patients regarding issues of prenatal diagnosis, medical genetics, and genetic counseling and testing options, (Code 9.d.);

(B) Provide technical expertise and support to HRSA staff in the development and updating of billing instructions, (Code 7.d.);

(C) Authorize facilities to bill for genetic counseling services, (Code 7.d.);

(D) Authorize and maintain a listing of approved providers and provider eligibility – American Board of Genetic Counseling credentialed providers, in coordination with HRSA, (Code 7.d.); and

(E) Assess access issues by tracking the number of genetic counseling services provided to clients throughout Washington State, (Code 7.b.).

ii. Deliverables. The Contractor shall provide to HRSA:

(A) Annual assistance with Prenatal Diagnosis Genetic Counseling billing instructions.

(B) An annual listing of all eligible facilities and providers.

(C) An annual tracking document demonstrating trends in service delivery based on billings.

(b) **Population Served:** Pregnant women who receive prenatal diagnosis genetic counseling.

(c) **MER:** Using the First Steps database, or other similar source, the MER will be determined by tracking all births in Washington State and calculating the percentage of those births that are Medicaid.

(14) Quality Assurance Monitoring

DOH Contact: Patti Rathbun, Phone: (360) 236-4067
HRSA Contact: Barbara Lantz, Phone: (360) 725-1640

(a) **Program Description:** The purpose of the monitoring is to perform quality assurance activities in support of Medicaid programs such as Healthy Options (HO), the Washington Medicaid Integration Partnership (WMIP), and the Medicare/Medicaid Integration Project (MMIP) in the evaluation of contracted Managed Care Organizations (MCOs) to determine compliance with federal, state regulations and contract requirements.

i. Primary MAM activities performed. All activities below shall be Coded 7.b. The Contractor shall:

(A) Review and evaluate materials from contracted MCOs to determine compliance with the federal Balanced Budget Act regulations, state regulations, and contract requirements;

(B) Provide technical advice and support to HRSA in updating/modifying preassessment materials and forms related to provider selection/credentialing and recredentialing requirements and delegated credentialing;

(C) Participate in and facilitate monthly Quality Assurance Monitoring Activity meetings;

(D) Review and evaluate "corrective action plans" from MCOs determined to be out of compliance; and

(E) Provide technical assistance to credentialing programs at MCOs, as requested.

ii. Deliverables. The Contractor shall:

(A) Interview MCO staff either in person or onsite; to gather additional information, determine compliance, and discuss findings.

(B) Prepare a written report documenting materials reviewed and findings of review.

(C) Provide technical assistance to credentialing programs at MCOs when requested.

(D) Evaluate MCOs' corrective action plans and determine whether the plans are sufficient or if additional changes are required.

(b) **Population Served:** Medicaid eligible infants, children and adults.

(c) **MER:** The population served is Medicaid eligible, thus the MER is 100%. All staff time allocated to MAM activities will be reimbursed at 50% FFP.

(15) HIV/AIDS Client Support Services

DOH Contacts: Richard Aleshire or designee/successor, Phone: (360) 236-3477
Teri Eyster or designee/successor, Phone: (360) 236-3449
HRSA Contact: Catherine Fisher or designee/successor, Phone: (360) 725-1357

(a) Program Description: The purpose of the HIV/AIDS Client Support Services program is to assure access to Medicaid services for people with HIV/AIDS, including the Early Intervention Program (EIP) for medical insurance and pharmacy benefits.

i. Primary MAM activities performed. The Contractor shall:

(A) Verify Medicaid eligibility for all EIP applications, using the Automated Client Eligibility System (ACES), (Code 2.b.);

(B) Assist clients with completing a Medicaid application, (Code 2.b.);

(C) Inform potentially eligible clients about Medicaid programs and provide information and materials about how they can access Medicaid, (Code 1.b.);

(D) Coordinating and monitoring the delivery of Medicaid services for EIP clients, including activities to keep clients connected to Medicaid services, (Code 9.b.);

(E) Provide training and technical assistance/information concerning Medicaid-covered services and Medicaid application assistance to EIP/Medicaid clients and stakeholders, (Code 8.b.**)**;

(F) Monitor EIP client compliance with mandatory policy requiring EIP clients to complete a Medicaid application, (Code 9.b.); and

(G) Monitor and project budget related to services being provided to and for Medicaid clients, (Code 10).

ii. Deliverables:

(A) The Contractor shall:

- Provide quarterly data reports to HRSA.
- Provide copies of EIPs' monthly enrollment/demographic report on a quarterly basis.
- Attend biannual meetings between HRSA Contact and EIP eligibility supervisor to ensure contract activities are running smoothly.
- Update the section of the manual material for Medicaid eligibility workers, relevant to the EIP program.

(B) HRSA Contact shall:

- Be available to assist the EIP with Medicaid eligibility and other related questions.

(b) **Population Served:** Medicaid eligible individuals with HIV/AIDS.

(c) **MER:** The MER shall be determined quarterly from client data (the percentage of the client population that is on Medicaid).

4. Activity Codes.

Participating Contractor staff shall use the following activity codes when completing the time study.

Code 1. a. NON-MEDICAID OUTREACH - U

Use this code when performing activities that inform individuals about their eligibility for non-Medicaid medical, social, vocational and educational programs and how to access them; and/or describing the range of benefits covered under these programs and how to obtain them. Examples of these activities

include:

- Informing families about non-Medicaid health and wellness programs and how to access these programs and services, such as exercise classes, cooking for diabetes management, flu shots, etc.
- Informing families about activities that educate individuals about the benefits of healthy life-styles and practices.
- Informing individuals and families about general health education programs or campaigns that address life-style changes in the general population (e.g., dental caries prevention, anti-smoking, alcohol reduction, etc.).
- Conducting outreach campaigns that encourage persons to access social, educational, legal or other non-medical services.
- Developing outreach materials such as brochures or handbooks for these "non-Medicaid" programs.

Code 1. b. MEDICAID OUTREACH - TM/50 Percent FFP

Use this code when performing activities that inform eligible or potentially eligible individuals about Medicaid programs and how to access them. Such activities include bringing potential eligibles into the Medicaid system for the purpose of the eligibility process. The following are examples of activities that are considered Medicaid outreach:

- Informing eligible and potentially eligible individuals and families about the benefits and availability of Medicaid-covered services, and encouraging them to apply.
- Maintaining, updating, printing and distributing educational materials about Medicaid programs and services.
- Encourage individuals and families to access services provided by the Medicaid program.
- Provide information about the First Steps program, Medicaid, and EPSDT and encourage callers and website users to be screened and to receive preventive prenatal and/or well child care, including immunizations and other preventive services covered by Medicaid.
- Provide health information and information about Medicaid-covered programs and services.
- With the goal of directing potential eligibles to enroll in Medicaid, publicize WithinReach in order to encourage potential Medicaid applicants to call for more information.

Code 2. a. FACILITATING APPLICATION FOR NON-MEDICAID PROGRAMS – U

Use this code when informing an individual or family about programs not covered by Medicaid, such as food stamps, day care, legal aid, and other social or educational programs, as well as health and wellness programs not covered by Medicaid, such as flu shots and exercise programs, and referring them to the appropriate agency to complete an application. Examples of these activities include:

- Explaining the eligibility process for non-Medicaid programs, including health and wellness programs not covered by Medicaid.
- Assisting the individual or family collect/gather information and documents for a non-Medicaid program application.
- Assisting the individual or family in completing the application.
- Developing and verifying initial and continuing eligibility for non-Medicaid programs.
- Providing necessary forms and packaging all forms in preparation for the eligibility determination for a non-Medicaid program.

Code 2. b. FACILITATING MEDICAID ELIGIBILITY DETERMINATIONS - TM/50 Percent FFP

Use this code when assisting an individual or family in the application process for Medicaid programs and services.

- Verifying an individual's current Medicaid eligibility status for purposes of the Medicaid eligibility process.
- Explaining Medicaid eligibility rules and the Medicaid eligibility process to prospective applicants.
- Assisting individuals or families to complete a Medicaid eligibility application.
- Gathering information related to the application and eligibility determination for an individual, including resource information and third party liability information as a prelude to submitting a formal Medicaid application.
- Providing necessary forms and packaging all forms in preparation for the Medicaid eligibility determination.
- Referring an individual or family to the local Community Service Office to make application for Medicaid benefits.

Code 3. ACTIVITIES NOT RELATED TO MEDICAID SECRVICES – U

Use this code for activities paid by the Contractor that are not medical or Medicaid-related, including non-Medicaid health and wellness activities, social services, educational services, teaching services, employment and/or job training.

Code 4. DIRECT MEDICAL SERVICES - U

Use this code when providing direct care, medical/dental treatment, and/or clinical counseling services to an individual, included but not limited to:

- Providing medical/dental/mental health/chemical dependency counseling treatment services.
- Conducting medical/dental/mental health/chemical dependency assessments/evaluations and diagnostic testing and preparing related reports.
- Providing personal aide services covered by Medicaid.
- Providing speech, occupational, physical and other therapies.

Code 5. a. ARRANGING TRANSPORTATION FOR NON-MEDICAID SERVICES – U

Use this code when assisting an individual in obtaining transportation to social, vocational, and/or educational programs and/or medical, health and wellness services not covered by Medicaid.

- Assisting a client in obtaining transportation to a job interview, cooking class, school, or other service or activity not covered by Medicaid.

Code 5. b. ARRANGING TRANSPORTATION IN SUPPORT OF MEDICAID COVERED SERVICES - PM/50 Percent FFP

Use this code when assisting an individual in obtaining transportation to services covered by Medicaid. This does not include the provision of the actual transportation service or the direct costs of the transportation *(bus fare, taxi fare, etc.)*, but rather the administrative activities involved in arranging transportation.

- Calling a Medicaid transportation broker to assist a client in obtaining transportation to a medical appointment, or other service covered by Medicaid.

Code 6. a. NON-MEDICAID TRANSLATION – U

Use this code when providing translation services for non-Medicaid activities. Non-Medicaid translation can be reported in two ways: As a separate non-Medicaid code (Code 6.a.) or as an example within one or more other non-Medicaid activity codes.

- Arranging for or providing translation services *(oral or signing services)* that assist the individual to access and understand medical and healthcare services not covered by Medicaid, as well as for social, educational, and vocational services.
- Developing translation materials that assist individuals in accessing and understanding social, educational, and vocational and non-Medicaid medical and healthcare services.

Code 6. b. TRANSLATION RELATED TO MEDICAID COVERED SERVICES – PM/50 Percent FFP

Translation may be allowable as a Medicaid-claimable administrative activity, including translation in a direct service context, if it is not included and paid for as part of the medical assistance service. However, translation must be provided either by separate units or separate employees performing solely translation functions, and it must facilitate access to Medicaid covered services. Employees who provide Medicaid translation services may use this code. Include related paperwork, clerical activities or staff travel required to perform these activities.

- Calling a Medicaid interpreter services broker to assist a client in obtaining interpreter services *(oral and signing)* for a medical appointment, or other service covered by Medicaid.
- Developing translation materials that assist individuals to access and understand necessary care or treatment covered by Medicaid.

Code 7. a. PROGRAM PLANNING, POLICY DEVELOPMENT, AND/OR INTERAGENCY COORDINATION RELATED TO NON-MEDICAID SERVICES - U

Use this code when performing activities associated with developing strategies to improve the coordination and delivery of non-Medicaid services to patients/Washington State residents. Non-Medicaid services include social services, educational services, and vocational services, as well as medical and other healthcare services that are not covered by Medicaid. (Only employees whose position descriptions include program planning, policy development and interagency coordination may use this code).

- Developing strategies to assess or increase the capacity of non-Medicaid programs.
- Identifying gaps or duplication of non-Medicaid services (e.g., social, vocational educational and state mandated medical and general health care programs) available to patients, and developing strategies to improve the delivery and coordination of these services.
- Developing procedures for tracking families' requests for assistance with non-Medicaid services and the providers of such services.
- Analyzing non-Medicaid data (e.g. family planning data) related to a specific program, population, or geographic area.
- Working with other agencies providing non-Medicaid services to improve the coordination and delivery of services and to improve collaboration around the early identification of problems not addressed by Medicaid-covered programs and services.

- Developing advisory or work groups of professionals to provide consultation and advice regarding the delivery of non-Medicaid services.
- Oversight of non-Medicaid WithinReach activities such as Breastfeeding Coalition and Immunization Coalition.
- Any program or policy development activities related specifically to non-Medicaid populations.

Code 7. b. PROGRAM PLANNING, POLICY DEVELOPMENT, AND/OR INTERAGENCY COORDINATION RELATED TO MEDICAID SERVICES - PM/50 Percent FFP

Only employees whose position descriptions include program planning, policy development and interagency coordination may use this code. Examples of these activities include:

- Monitoring; consultation meetings; interagency work groups; and/or planning activities impacting Medicaid service delivery and access to care.
- Research and evaluation activities concerning Medicaid-related services for the purpose of program planning and policy improvement.
- Coordinate/collaborate with stakeholders and state/federal agencies about Medicaid for policy development, information sharing, and improved service delivery.
- Developing advisory or work groups of professionals to provide consultation and advice regarding the delivery of Medicaid services.
- At the request of the Medicaid agency, direct assistance in program planning, policy development, WAC and billing instructions, including evaluation activities concerning the Medicaid population and Medicaid providers.
- Identify and share with the Medicaid agency Medicaid reimbursement policy and related issues impacting Medicaid providers.
- Administrative oversight of the WithinReach subcontract which is exclusively dedicated to Medicaid activities.
- Provide technical and capacity development assistance to potential/current Medicaid providers.

For the HIV/AIDS Targeted Case Management Program:

- Review Title XIX HIV/AIDS Case Management provider applications and forward to HRSA recommended approvals for contract processing.
- Maintain policies and procedures for the daily operations of the Title XIX HIV/AIDS Case Management Program, including, but not limited to, recommending payment rates, monitoring provider compliance with established scope of services and standards of service delivery.
- Provide quality assurance activities/measures, including technical assistance to Title XIX HIV/AIDS populations through training of providers, access to clinical consultation and development of continuing quality improvement plans.
- Facilitate the smooth transition to Medicaid services for eligible HIV/AIDS populations through assuring coordination of services to this population; Assure availability of state/local government matching funds for all payable claims submitted within 365 days of the provision of service.

Code 7. c. PROGRAM PLANNING, POLICY DEVELOPMENT, AND INTERAGENCY COORDINATION RELATED TO SPMP NON-MEDICAID SERVICES - U

See Section 7 Skilled Professional Personnel Training for SPMP description; only employees whose

position descriptions include program planning, policy development and interagency coordination may use this code.

- Provide medical expertise/knowledge for non-Medicaid program planning and policy development regarding medical issues not related to Medicaid.
- Staff using this code meets all criteria of a SPMP as defined in Section 7, and the SPMP credentials are required for the activity.

Special Note: Staff using this code that meets all SPMP criteria, but who are not performing activities that require medical expertise/knowledge for non-Medicaid program planning and policy development regarding issues not related to Medicaid, shall code such activities to Code 7.a.

Code 7. d. PROGRAM PLANNING, POLICY DEVELOPMENT, AND INTERAGENCY COORDINATION RELATED TO SPMP MEDICAID SERVICES - PM/75 Percent FFP

See Section 7 Skilled Professional Personnel Training for SPMP description; only employees, whose position descriptions meet SPMP criteria, have been approved by CMS and include program planning, policy development and interagency coordination may use this code.

- Provide medical expertise/knowledge to the Medicaid agency for program planning and policy development regarding medical issues related to Medicaid;
- Staff using this Code must meet all criteria of a SPMP as defined in Section 7. SPMP, Claiming, and the SPMP credentials are required for the activity.

Special Note: Staff using this code that meets all SPMP criteria, but who are not performing activities that require medical expertise/knowledge for Medicaid program planning and policy development regarding issues related to Medicaid, shall code such activities to Code 7.b.

Code 8. a. NON-MEDICAID RELATED TRAINING - U

Use this code when coordinating, conducting, or participating in training activities for staff regarding the benefit of programs other than the Medicaid program.

- Participating in or coordinating training that improves the delivery of healthcare programs other than those covered by Medicaid.
- Participating in or coordinating training that enhances IDEA child find programs, self-help sobriety programs, WIC, exercise workouts, healthy cooking, parenting classes, etc.
- Training that, results in staff receiving continuing education credits (See Code 8 d. for the SPMP exception).

Code 8. b. TRAINING RELATED TO MEDICAID ADMINISTRATIVE ACTIVITIES - PM/50 Percent FFP

Use this code when coordinating, conducting, or participating in training activities designed to improve access to Medicaid covered services via enhanced referrals, outreach and assistance. (Note, training that enhances the education/professional knowledge/skills needed in providing direct medical and/or Medicaid-covered services should be treated as non-Medicaid Services).

- Participating in or coordinating training that improves access to Medicaid-covered services.
- Participating in or coordinating training that enhances capacity for identification, intervention, screening and referral of individuals to Medicaid-covered services.
- Participating in or coordinating training that improves Medicaid outreach.

- Participating in or coordinating training for provision of assistance with Medicaid application and eligibility determination.
- Training having to do specifically with a Medicaid program, Medicaid program administrative requirements or eligibility (e.g. Healthy Options, Medicaid managed care, First Steps, Targeted Case Management, EPSDT, etc…).

Code 8. c. TRAINING RELATED TO SPMP NON-MEDICAID ADMINISTRATIVE ACTIVITIES – U

See Section 7. Skilled Professional Medical Personnel Training for SPMP description.

Use this code when receiving SPMP training not related to Medicaid-covered services. The training must result in SPMP staff maintaining their credentials as SPMP staff (certification, licensing, registration, etc. **HRSA shall not reimburse for training of medical providers enrolled in the Medicaid program, and/or who provide direct services to Medicaid recipients.**

- Training received by SPMP qualified contractor staff resulting in continuing education credits. The training results in enhanced skills/and, or knowledge that can be used for medically necessary non-Medicaid related services, policy development and/or interventions. Examples of non-Medicaid SPMP training may include flu prevention or biofeedback therapy. Clerical staff that is directly supervised by the SPMP staff may also use this code when directly supporting the SPMP activity. (The Contractor is expected to consult with the HRSA Program Manager regarding questions and decisions on how best to code activities thought to qualify as SPMP training activities).

Special Note: Staff using this code that meets all SPMP criteria, but who are not performing activities that require medical expertise/knowledge for non-Medicaid program planning and policy development regarding issues not related to Medicaid, shall code such activities to Code 8.a.

Code 8. d. TRAINING RELATED TO SPMP MEDICAID ADMINISTRATIVE ACTIVITIES - PM/75 Percent FFP

See Section 7. Skilled Professional Medical Personnel Training for SPMP description.

Use this code when receiving SPMP training related to Medicaid administrative activities. The training must result in SPMP staff maintaining their qualifications as SPMP staff (certification, licensing, registration, etc.). **PLEASE NOTE:** Reimbursement for training is unique to SPMP administrative staff. The 75% enhanced funding is offered as an incentive to employ educated, trained, and experienced medical professionals to assist in the operations of the Medicaid program. **HRSA shall not reimburse for training of medical providers enrolled in the Medicaid program, and/or who provide direct services to Medicaid recipients.**

- Training received by SPMP qualified contractor staff resulting in continuing education credits. The training will assist staff in developing enhanced skills and/or knowledge that can be used to help ensure the best quality Medicaid program service delivery, including, but not limited to best practices, effective clinical interventions, policy, rules, etc. Clerical staff that is directly supervised by the SPMP staff may also use this code when directly supporting the SPMP activity. (The Contractor is expected to consult with the HRSA Program Manager regarding questions and decisions on how best to code activities thought to qualify as SPMP training activities).

Special Note: Staff using this code that meets all SPMP criteria, but who are not performing activities that

require medical expertise/knowledge for Medicaid program planning and policy development regarding issues related to Medicaid, shall code such activities to Code 8.a.

Code 9. a. REFERRAL, COORDINATION, AND MONITORING OF NON-MEDICAID SERVICES – U
(Only employees whose position descriptions include referral, coordination and monitoring activities may use this code).

Use this code when making referrals for, coordinating, and/or monitoring the delivery of services not covered by Medicaid. The activity is typically focused on a specified patient or individual.

- Making referrals for and coordinating access to medical and other healthcare services not covered by Medicaid (e.g. flu shots, exercise programs, childbirth and parenting classes, etc).
- Making referrals for and coordinating access to social and educational services such as child care, employment, job training, and housing.
- Making referrals for, coordinating, and monitoring the delivery of scholastic, vocational, and other non-health related examinations.
- Gathering any information that may be required in advance of these non-Medicaid related referrals.
- Participating in a meeting/discussion to coordinate or review a patient member's need for services not covered by Medicaid.

Code 9. b. Referral, Coordination, and Monitoring of Medicaid Services - PM/50 Percent FFP.
(Only employees whose position descriptions include referral, coordination and monitoring activities may use this code).

Special Note: This code shall not be used for "coordination and monitoring" activities for any patient receiving mental health services through the Regional Support network or targeted case management chemical dependency services.

Use this code when making referrals for, coordinating, and/or monitoring the delivery of medically-related services when the activity is not integral to or an extension of a medically-related service. The activity is typically focused on a specified patient or individual. This may include, but is not limited to the following activities.

- Identifying and referring patients who may be in need of Medicaid-covered services, such as First Steps or Take Charge family planning services.
- The initial referral only to mental health or chemical dependency treatment services.
- Making referrals for and/or coordinating medical or physical examinations and necessary medical/dental evaluations.
- Screening patients' charts to identify any need for referral and/or follow-up services (e.g., EPSDT screens, immunizations, PAP tests, mammograms, etc.).
- Referring patients for necessary medical or dental services covered by Medicaid.
- Arranging for any Medicaid covered medical/dental diagnostic or treatment services that may be required as the result of a specifically identified medical/dental condition.
- Gathering any information that may be required in advance of an initial medical/dental/mental health referral.
- Participating in a meeting/discussion to coordinate or review a patient's needs for health-related services covered by Medicaid, provided that such participation is not an extension of a direct service.

- Providing follow-up contact to ensure that a patient has received the prescribed medical/dental services covered by Medicaid.
- Coordinating the delivery of medical/dental services for a patient with special/severe health care needs.
- Coordinating the completion of prescribed services, termination of services, and the referral of the patient member to other Medicaid service providers as may be required to provide continuity of care.
- Providing information to other staff on the patient's medical/dental services and plans provided that such participation is not an extension of a direct service.
- Coordinating medical/dental service provision as appropriate.

Code 9. c. Referral, Coordination, and Monitoring of SPMP Non-Medicaid Services – U

See Section 7 Skilled Professional Medical Personnel Training for SPMP description. (Only employees whose position descriptions meet SPMP criteria; have been approved by CMS and whose position descriptions include referral, coordination and monitoring activities may use this code).

Special Note: This code shall not be used for "coordination and monitoring" activities for any patient receiving mental health services through the Regional Support network or targeted case management chemical dependency services.

Use this code when the SPMP qualifications are essential to any non-Medicaid activity that may be performed, and when those activities could not be provided by any other staff without such qualifications. Examples of such activities include:

- Acting as a consultant for quality assurance purposes regarding non-Medicaid related billings.

Special Note: Staff using this code that meets all SPMP criteria, but who are not performing activities that require medical expertise/knowledge for non-Medicaid program planning and policy development regarding issues not related to Medicaid, shall code such activities to Code 9.a.

Code 9. d. Referral, Coordination, and Monitoring of SPMP Medicaid Services - PM/75 Percent FFP

See Section 7 Skilled Professional Medical Personnel Training for SPMP description. (Only employees whose position descriptions meet SPMP criteria; have been approved by CMS and whose position descriptions include referral, coordination and monitoring activities may use this code).

Special Note: This code shall not be used for "coordination and monitoring" activities for any patient receiving mental health services through the Regional Support network or targeted case management chemical dependency services.

Use this code when the SPMP qualifications are essential to the activity being performed, and those activities could not be provided by any other staff without such qualifications. Examples of such activities include:

- Acting as a consultant to HRSA for quality assurance purposes regarding complicated patient medical diagnoses and associated medical billings (i.e. genetics). This activity may involve patient medical chart review.

Special Note: Staff using this code that meets all SPMP criteria, but who are not performing activities that require medical expertise/knowledge for Medicaid program planning and policy development regarding

issues related to Medicaid, shall code such activities to Code 9.b.

Code 10. General Administration Reallocated - R

Use this code when performing administrative activities that are not directly assignable to other program activities. Include related paperwork, clerical activities, or staff travel required to perform these general administrative activities. Note that DOH administrative staff expenses (usually including accounting, payroll, executive direction, etc.), are only allowable through the application of an approved indirect cost rate. Below are examples of general administrative activities, but they are not all inclusive.

- Taking paid lunch, other paid breaks, paid vacation and sick leave, or other paid time not at work.
- Training in MAM requirements, including activity code and time study methodology.
- Reviewing business procedures and rules.
- General research-related activities.
- Providing general supervision of staff, including supervision and evaluation of employee performance.
- Other general administrative activities of a similar nature as listed above that cannot be specifically identified under other activity codes.

Code 11. a. NON-MEDICAID PROVIDER RECRUITMENT - U

- Activities to recruit and retain non-Medicaid medical and/or social service providers/programs for rural and urban medically underserved communities in Washington State.
- Activities to recruit non-Medicaid covered social services or related programs, such as low-income housing or food banks for underserved communities in Washington State.
- Providing information/technical assistance to medical providers concerning private insurance reimbursement and billing requirements.

Code 11. b. MEDICAID PROVIDER RECRUITMENT - PM/50 Percent FFP

- Activities to recruit and retain Medicaid providers for rural and urban medically underserved communities in Washington State.
- Activities intended to assure quality health care service availability and access to care for Medicaid or Medicaid eligible people.
- Providing information/technical assistance to medical providers concerning Medicaid reimbursement and billing requirements.

Code 12. a. DOH NON-MEDICAID CONTRACT OVERSIGHT - U

This code will be used only by the designated DOH Program Administrator for activities not related to this MAM Agreement, and not related to Medicaid.

- DOH administrative activities associated with non-Medicaid related contract oversight, monitoring, consultation and technical assistance.

Code 12. b. DOH "MEDICAID ONLY" PROGRAM/CONTRACT OVERSIGHT - TM/50 Percent FFP

This code will be used only by the DOH Program Administrator for the following activities:

- For the DOH Program Administrator only, representing DOH in communication and collaboration with the Medicaid agency regarding issues related to this Agreement and its development including amendments, monitoring activities, technical assistance and MAM training to DOH program staff.

5. MAM Claiming Documentation.

The Contractor shall maintain and be able to support all MAM claims submitted to HRSA. The documentation for administrative activities must clearly demonstrate that the activities performed directly support the administration of the Medicaid program. The administrative claiming records must be made available for review by HRSA, State Auditor and federal staff upon request during normal working hours (section 1902(a) (4) of the Act, implemented at 42 CFR 431.17).

Documentation maintained in support of administrative claims must be sufficiently detailed to permit federal staff to determine whether the activities are necessary for the proper and efficient administration of the state Medicaid plan. Additional guidance regarding documentation for compensation of salary and wages is found in OMB Circular A-87, Attachment B, Section 11.h. (5).

Personnel activity reports or equivalent documentation must meet the following standards. They shall:

a. Reflect an after-the-fact distribution (i.e., distribution following completion of the activity) of the actual activity of each employee;

b. Account for the total activity for which each employee is compensated;

c. Be prepared at least monthly and shall coincide with one or more pay periods; and

d. Be signed by the employee as being a true statement of activities and the employee/office shall retain documentation to support the report.

Special Note: ASMB C-10, the U.S. Department of Health and Human Services' implementation guide for OMB Circular A-87, provides further guidance on the requirements and circumstances dictating the frequency of time and effort reporting.

Other principles related to documentation and documentation requirements that apply, in addition to the above requirements, are:

a. The documentation related to salaries and wages, including personnel activity reports must be available;

b. Accounting records shall be supported by source documentation such as canceled checks, paid bills, payrolls, contract and sub-grant award documents;

c. Case management services based on time studies are an acceptable form of documentation for a given period;

d. Costs shall be verified as being incurred in a particular federal program;

e. Undocumented personnel costs are not allowed; and

f. Adequate documentation for labor costs is required.

6. Calculating and Applying the Medicaid Eligibility Rate (MER) in MAM Claiming. (Also see Section 3. Statement of Work for each program's MER description.)

The Contractor shall establish the proportional Medicaid share for those activity codes marked as PM. The number of Medicaid enrolled individuals shall be determined for each program that is submitting a claim. This number serves as the numerator in a fraction, with the denominator being the total population served by a participating program. This fractional value is then applied to the total costs applicable to the proportional Medicaid share time codes, to determine the costs applicable to Medicaid administrative activities. The Contractor shall certify that the MER used for each participating program is true and correct, and that there is sufficient documentation to support each MER. The Contractor shall complete and submit a MER Certification Form with each quarterly billing (see Exhibit D - Sample MER Certification Form).

Example of Medicaid Share

The following example establishes how much of the costs related to an identified proportional Medicaid activity should be allocated to Medicaid. In other words, the amount of FFP (Title XIX match) is determined by applying the MER to the total claimable costs.

MAM Activity Code 9b = (Referral, Coordination, and Monitoring of Medicaid Services, PM/50% FFP). The CHILD Profile time study data shows that a total of $1,500 of all participating staff's time is allocated to this activity code (The Gross Claimable Amount = $1,500).

MER: Assume 20% of the population served by CHILD Profile is eligible for Medicaid

Here is how the claim would be calculated:

Gross Claimable Amount = $1,500

Multiplied by the MER (20 percent):

$1,500 X .20 = $300

Multiplied by the FFP Rate (50 percent):

$300 X .50 = $150

Net Claimable Amount = $150 FFP

There are two MAM Activity Codes that do not require the use of a MER (100% of the costs associated with these activities are reimbursable at 50% FFP):

(1) Medicaid Outreach (Code 1b); and

(2) Facilitating Medicaid Eligibility Determinations (Code 2b).

If submitting a claim for only these activities, the application of the MER is not required (discounting is not applicable). The only other circumstance where a MER may not be applicable is when 100% of the population served by a program is Medicaid eligible. In this circumstance the MER = 100%.

Special Note: An individual's Medicaid eligibility may be verified free of charge through the

Washington State Medicaid (WAMED) web-address at:

https://wamedweb.acs-inc.com/wa/general/home.do

7. Skilled Professional Medical Personnel (SPMP) Claiming.

Only DOH state staff may use SPMP activity codes. Subcontracted staff cannot claim SPMP activities. In order to claim at the enhanced rate of 75% FFP for SPMP activities, all of the following SPMP applicable criteria must be satisfied:

- The expenditures must be for activities that are directly related to the administration of the Medicaid Program, and as such do not include expenditures for Medical Assistance;
- The SPMP must have professional education and training in the field of Medical care or appropriate medical practice (the Contractor shall maintain documentation of degrees, licenses, certifications, etc., that support the SPMP activities for audit/monitoring purposes);
- Staff without the professional education, training, degrees, licenses, certifications, etc. are not able to perform the same job duties as the SPMP;
- The SPMP must be in a position that has duties and responsibilities that require professional knowledge and skills (job descriptions supporting the SPMP functions shall be kept on file for audit/monitoring purposes);
- A state-documented employer-employee relationship must exist between the Medicaid agency and the SPMP and directly supporting staff;
- The directly supporting staff is secretarial, stenographic, and copying personnel and file and records clerks who provide clerical services that are directly necessary for the completion of the professional medical responsibilities and functions of the SPMP staff. The SPMP must directly supervise the supporting staff and the performance of the supporting staff's work;
- The rate of 75% FFP is available for SPMP and directly supporting staff of other public agencies if all of the above criteria are met. This Agreement will serve as the required written agreement between HRSA and the Contractor; and
- FFP must be prorated for split functions of SPMP and directly supporting staff.

Additional Requirement: CMS must first review and approve all DOH program "positions" intending to claim SPMP activities at the enhanced, 75% FFP reimbursement rate. The Contractor shall provide CMS with the following SPMP personnel and supporting staff information:

- Job titles, position descriptions, position functions, job announcements, position postings, etc.; and
- SPMP staff qualifications (education & experience).

Once CMS has authorized that a specific DOH position may claim SPMP as applicable, no further CMS review in the future is required as long as the position description and qualifications remain unchanged.

(For a detailed description of SPMP see the CMS SPMP Guide - *Title XIX Financial Management Review Guide, # 1: Skilled Professional Medical Personnel* which can be found at the HRSA website at http://fortress.wa.gov/dshs/maa/mam).

8. Billing and Payment Procedure.

a. Billing

(1) The Contractor shall submit quarterly billings to HRSA that meet all expectations set forth in this

Agreement and that meet all federal claiming guidelines. Payment for work performed shall be subject to all provisions of this Agreement. The Contractor shall bill HRSA for Medicaid administrative match activities performed during the contracted period of performance. The Contractor will make available all back-up documentation to support quarterly billings upon request.

(2) The Contractor shall not submit billing, and HRSA shall not reimburse any amount that exceeds the Contractor's available state match. HRSA shall reimburse only for work performed on or after the beginning date and on or before the expiration date of this Agreement, including properly executed amendments and extensions.

(3) The Contractor shall submit claims only for MAM allowable activities. HRSA shall not reimburse for administrative expenditures related to, or in support of, services that are not allowable for reimbursement by Medicaid and which are not included in the state Medicaid plan. In addition, HRSA does not reimburse for health care services that are rendered free of charge to the general population.

b. Payment

Following receipt of correctly submitted A19-1A invoice vouchers, HRSA shall reimburse the Contractor using their state-wide vendor number, via an interagency payment (IAP).

c. Indirect Costs

Allowable personnel costs, travel costs, contractual expenditures and Goods and Services constitute direct claimable costs. The Contractor shall claim indirect costs in accordance with OMB Circular A-87. The Contractor shall assure that costs claimed as direct costs do not duplicate costs claimed through the application of the indirect cost rate. The indirect rate (stated as a percentage) is to be applied to the sub-total amount claimed after direct cost calculations are complete. The approved indirect cost rate shall be applied to each quarter billing within its applicable fiscal year. If the Contractor does not have an approved indirect rate for the current fiscal year, the most recently approved indirect rate may be used. Subcontractors may use a federally approved indirect rate, or rate assigned by the cognizant entity. Indirect costs will be billed at the 50% non-enhanced FFP rate. The pass through indirect rate for subcontracts is not claimable.

d. Timely Filing Requirements

(1) The Contractor shall submit an A19-1A Invoice Voucher (see Exhibit A for Sample A19-1A)) to HRSA for each billable quarter of the contracted period. A separate billing worksheet detailing MAM related expenses by participating program, including the MER, used, must be included with the A19-1A. Upon approval, HRSA will then use the Contractor's state-wide vendor number to generate an interagency payment (IAP). The first quarter of this Agreement begins January 1, 2008 and ends March 31, 2008. The Agreement end date is December 31, 2012.

(2) Each A19-1A submitted shall include the dollar amounts, by program, billed by federal and state match rates and the statement:

> "Under the terms of the Contract between the parties, I certify that these expenses were incurred for allowable MAM services provided to potential Medicaid participants or for Medicaid administrative purposes to Medicaid covered participants. I also certify that funds used to claim FFP are available, appropriate, and in accordance with the Code of Federal Regulation Title 42 section 433.51, (42 CFR 433.51)."

(3) The Contractor shall submit claims for payment to HRSA each quarter. Per WAC 388-05-0010, claims for payment received after twelve months may not be paid. HRSA may grant exceptions to the twelve-month period for initial claims when billing delays are caused by either of the following:

(a) HRSA's certification or authorization of services for a client for a retroactive period; or

(b) The Contractor proves to HRSA's satisfaction that there are other extenuating circumstances.

e. Allowable Costs

(a) Personnel Costs

For purposes of MAM claiming, the Contractor shall limit calculation of personnel costs to salary plus benefits, using payroll documents. The actual percentage of time spent that quarter on allowable reimbursable activities by each staff person is then multiplied by the personnel costs for that staff person to produce the claimable costs for that person's activities. Salary costs for the quarter shall be readily determinable and based on data available from the Contractor accounting office. These data shall tie to the quarterly payroll tax reports, providing a good audit trail for what is claimed as salary paid to the individual staff person for whom costs are claimed. In addition to salary, personnel costs shall include payroll taxes and fringe benefits. The cost of these benefits may be tied to the salary of an individual staff person, or a multiplier for benefits (that is, payroll taxes and fringe benefits as a percentage of salaries) may be calculated for Contractor or sub-contractor staff of programs performing activities under this Agreement, based on accounting records. Personnel costs for contracted staff shall consist only of the compensation paid to or for that person, as documented by the Contractor accounting office.

(b) Travel Costs

In addition to personnel costs, the Contractor may claim travel costs incurred by Contractor and sub-contractor staff in connection with their MAM allowable activities. Allowable travel costs shall be limited to costs for travel incurred in conducting the specific allowable reimbursable activities documented on the timesheet. Reimbursement for travel is limited to documented transportation and hotel expenses, plus per diem and mileage at prevailing federal rates. Documentation of travel costs claimed shall be kept on-site by the Contractor for review by HRSA and/or CMS as requested.

(c) Goods and Services

The Contractor shall claim MAM reimbursement for allowable Goods and Services required for conducting the activities described in this Agreement. "Goods and Services" include usual and customary costs related to supporting MAM activities that are not: a) salary and benefits; b) travel; c) included in the Indirect Rate. Goods and Services include costs that can be documented through application of the time study percentage determined through allocation of 100% of expenditures in parallel coding (an exception is WithinReach, which uses a tally sheet). Costs associated with Goods and Services include such expenditures as rent and postage. The Contractor and any sub-contractors shall maintain records to document these expenditures.

For example: Grand Total rent costs = $1,000

MER = 23%

Percentage of paid activities that are to be reallocated = 25%

Percentage of paid activities solely attributable to Medicaid (TM) = 6%

Percentage of paid activities that are proportionately Medicaid (PM) = 19%

Percentage of paid activities that are not MAM-allowable = 50%

- Calculation for TM = (6/100) x .25 = 1.50%
- Calculation for MER = (19/100) x .25 = 4.75 x .23 = 1.09%
- 1.50% + 1.09% = 2.59%
- 1,000 x 2.59% = 25.90
- 25.90 x 50% = $12.95 FFP

(d) Sub-contracts

The Contractor may sub-contract to appropriate parties in order to increase the effectiveness and efficiency of MAM activities. All sub-contractors are subject to the same rules, regulations and conditions imposed on the Contractor, including MAM claiming and time study requirements.

f. Offset of Revenues

Certain revenues shall offset allocation costs in order to reduce the total amount of costs in which the federal government will participate. To the extent the funding sources have paid or would pay for the costs at issue, federal Medicaid funding is not available and the costs must be removed from total costs (See OMB Circular A-87, Attachment A, Part C., Item 4.a.). The following include some of the revenue offset categories which must be applied in developing the net costs:

- All “non-authorized” federal funds.
- All state expenditures which have been previously matched by the federal government.
- Insurance and other fees collected from non-governmental sources must be offset against claims for Medicaid funds.
- All applicable credits must be offset against claims for Medicaid funds. Applicable credits refer to those receipts or reduction of expenditure type transactions that offset or reduce expense items allocable to federal awards as direct or indirect costs.
- The Contractor shall not claim any federal match for administrative activities if its total cost has already been paid by the revenue sources above. A Contractor shall not be reimbursed in excess of its actual costs, i.e., make a profit.

g. Calculating General Administration Reallocated (R) Activities (Code 10):

R activities are reallocated across other codes based on the percentage of time spent on allowable/unallowable administrative activities. For examples of R activities see Section 4. Activity Codes, Code 10.

Grand Total activity costs = $100,000

MER = 23%

Percentage of paid activities that are to be reallocated = 25%

Percentage of paid activities solely attributable to Medicaid (TM) = 6%

Percentage of paid activities that are proportionately Medicaid (PM) = 19%

Percentage of paid activities that are not MAM-allowable = 50%

- Calculation for TM = (6/100) x .25 = 1.50
- Calculation for MER = (19/100) x .25 = 4.75 x .23 = 1.09
- 1.5 + 1.09 = 2.59%
- 100,000 x *2*.59% = 2,590
- 2,590 x 50% = $1295 FFP

9. Compliance: Federal Regulations.

a. The Contractor shall reference the Title XIX regulations (42 CFR, Parts 430-433) in all Contractor Agreements which include Title XIX administrative activities. For all Title XIX delegated programs and administrative activities included in this Agreement the Contractor shall be responsible for maintaining compliance with Medicaid federal regulations.

b. The Contractor shall accept responsibility for any disallowances and/or penalties that CMS may determine during an audit. These disallowances and/or penalties may result from claims that HRSA submitted on behalf of the Contractor's billing of Medicaid. If the Contractor bills and is paid administrative match money for services that are later found to be undelivered, ineligible for Medicaid administrative match, or not delivered in accordance with applicable standards, the Contractor shall be responsible for any disallowances and/or penalties and shall fully cooperate in the recovery of funds.

c. State Match/Certified Public Expenditure:

(1) This is a Certified Public Expenditure Agreement. The Contractor shall ensure that the Contractor's monetary share (also known as state match) for administrative match activities is non-federal money which has not been and shall not be used as match for federal money by the Contractor or any other agency.

(2) The Contractor shall also ensure that funds used as state match meet federal regulations regarding state match funding.

(3) State matching funds shall be available for Medicaid-related claimed activities and shall be within the Contractor’s control and budget.

(4) Funds donated by Medicaid providers shall not be used as state match unless prior approval has been granted by HRSA. Local funds used as state match must be from a government entity.

10. Training.

The HRSA Program Manager shall approve all MAM training materials; and shall provide MAM training to the DOH Program Administrator annually. The DOH Program Administrator, once trained by the HRSA Program Manager, shall train other participating Contractor staff.

All Contractor staff and any sub-contractor staff shall receive MAM training before participating in the time study. Time study and activity code requirements shall be reviewed by participating staff annually. The Contractor shall be responsible for training all participating staff and maintaining documentation of such training for review by HRSA and/or CMS staff as requested.

11. Monitoring Process.

a. The DOH Program Administrator and the HRSA Program Manager shall oversee monitoring of activities in this Agreement. The DOH Program Administrator shall:

(1) Coordinate communication and processes between the Contractor and HRSA regarding this Agreement;

(2) Participate as requested in all HRSA monitoring activities;

(3) Facilitate a DOH Contacts' meeting not less than annually;

(4) Provide technical assistance about contractual issues as needed to contract participants; and

(5) Oversee any amendments or developments pertaining to this Agreement.

b. The HRSA Program Manager shall:

(1) Coordinate communication and processes between HRSA and Contractor regarding this Agreement;

(2) Conduct monitoring visits once a year or as deemed necessary (see Exhibit E - Monitoring Tool);

(3) Provide technical assistance as needed to contract participants;

(4) Oversee any amendments or further development of this Agreement; and

(5) Review billings and authorize reimbursements.

12. Consideration.

a. Total consideration payable to Contractor under this Agreement is not a pre-set amount.

b. The FFP is a 50% reimbursement rate, except for appropriately documented SPMP activities which have been coded to PM/75 Percent activity codes, e.g., 7.d, 8.d, and 9.d (see Section 4. Activity Codes and Section 7. SPMP, Claiming).

13. Billing and Payment.

a. Invoice System. The Contractor shall submit invoices using State Form A19-1A Invoice Voucher, or such other form as designated by HRSA. Consideration for services rendered shall be payable upon receipt of properly completed invoices which shall be submitted to Todd Slettvet, HRSA Program Manager/or successor, by the Contractor not more often than monthly. The invoices shall describe and document to HRSA's satisfaction a description, by program; of the work performed, activities accomplished, the progress of the project, and fees. The rates shall be in accordance with those set forth in Section 12, Consideration, of this Agreement.

b. Payment. Payment shall be considered timely if made by HRSA within thirty (30) days after receipt and acceptance by Todd Slettvet, HRSA Program Manager/or successor, of the properly completed invoices. Reimbursements shall be sent to the address designated by the Contractor on page one (1) of this Agreement. HRSA may, at its sole discretion, withhold payment claimed by the Contractor for services rendered if Contractor fails to satisfactorily comply with any term or condition of this Agreement.

14. Insurance.

a. DSHS certifies that it is self-insured under the State's self-insurance liability program, as provided by RCW 4.92.130, and shall pay for losses for which it is found liable.

b. The Contractor certifies, by checking the appropriate box below, initialing to the left of the box selected, and signing this Agreement, that:

_____ ☐ The Contractor is self-insured or insured through a risk pool and shall pay for losses for which it is found liable; or

_____ ☐ The Contractor maintains the types and amounts of insurance identified below and shall, prior to the execution of this Agreement by DSHS, provide certificates of insurance to that effect to the DSHS contact on page one of this Agreement.

Commercial General Liability Insurance (CGL) – to include coverage for bodily injury, property damage, and contractual liability, with the following minimum limits: Each Occurrence - $1,000,000; General Aggregate - $2,000,000. The policy shall include liability arising out of premises, operations, independent contractors, products-completed operations, personal injury, advertising injury, and liability assumed under an insured contract. The State of Washington, DSHS, its elected and appointed officials, agents, and employees shall be named as additional insureds.